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CUMBERLAND COUNTY COUNCIL
EDUCATION COMMITTEE



The
School
Health
Service

1964

JOHN LEIPER

PRINCIPAL SCHOOL MEDICAL
OFFICER

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PREFACE

To the Chairman and Members of the Education Committee:

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present the Annual Report on the School Health Service for 1964.

The main events in the social history of Cumberland during the year centred on the opening of the West Cumberland Hospital in October by Her Majesty the Queen Mother, and the opening of Wyndham School at Egremont.

The impact of social change in both these spheres is further highlighted by the visit of Mr. Alec G. Dickson, of the Community Service Volunteers, in the summer, and the increasing challenge to youth and adolescents to help with their own hands those who are inadequate or handicapped and who live either in the community or are receiving treatment in hospital.

The great increase in the attendance and help given by school children at clubs and homes for the elderly and handicapped is probably one of the most remarkable developments in this decade, and whilst it must always be secondary to a firm family help it, nevertheless, has thrived under the care and promotion of the Director of Education, Mr. Gordon S. Bessey, so that one can see in the not too distant future the schools playing an even fuller part in the work of the community.

Progress has also been made in the administrative sphere, where a system of area administration has come into operation whereby three areas centred at Carlisle, Whitehaven and Workington, carry out day to day functions of the Health and Welfare Committee, including those of the School Health Service. It was noted right from the start that these areas would be contiguous with the education areas, and already a good link has been forged in administrative matters between area medical officers and area education officers, to the advantage of all concerned.

This area administration is linked closely with the formation of area committees under the Health, Housing and Welfare Committee to deal with day to day matters. I am most pleased

to report that the wishes of both the Director and myself were agreed to by the Council so that direct teacher representation on these area committees has been ensured. When viewed in the light of the broad representation already on these committees, I feel they indeed do reflect the basic and important aspects of local community thought in their particular areas.

The Joint Health and Education Sub-Committee has been retained and has also been given adequate representation of teachers. It will deal with all new developments and thoughts associated with the related health and welfare and education spheres of the authority's work.

This is, of course, a wide sphere of great responsibility and I look forward to viewing the meeting of this committee as a place where new thoughts and ideas can be examined critically, where pilot schemes can be started and from which pilot schemes can be advised, and where preliminary results of such schemes and, indeed, schemes from other places, may be examined.

Increasingly, the link which is being forged between the two departments shows that the meeting point between them is confused. Education being a life-long process and further education coming more to the fore, where does the health authority responsibility lie in respect of prevention of the killing disease of middle aged men, taking but one example? The authority, however, being forward looking has agreed to the appointment of a Health Education Officer to co-ordinate and lead the health education attack on illness and the promotion of positive health. This post is already being advertised and it is from this development that the greatest rewards are sought. Meanwhile, continuing propaganda by doctors, school nurses and health visitors proceeds, supported by films and group discussions in classes to prevent the start of smoking by school children, which if continued into later life will, no doubt, contribute to the one million deaths from lung cancer which are expected in this country by the end of the century.

Staffing difficulties have been experienced during the year in respect of two groups of officers, both being members of professions supplementary to medicine. The first is orthoptists, where recruitment is so difficult that at the time of writing it is planned to institute a scholarship scheme to enable the training

of suitable candidates. I feel also that many more careers masters and mistresses in the various schools should be more aware of this rewarding work associated with handicapped, and often only temporarily handicapped, children. The second group is speech therapists. The good work of the much reduced staff continues and here we have the advantage of being associated, albeit in a peripheral manner, with the new university department of speech therapy of the University of Newcastle. I am glad that the committee have taken my advice to introduce a scholarship scheme for speech therapists as well.

The year also evidenced the opening of the first "satellite" clinic at Salterbeck, Workington, and the value of such a clinic in relation to school health and its association with the neighbourhood schools is already apparent.

Moves are already being made towards the appointment of a child psychiatrist for this remote and isolated part of the North West of England which has a remand home, a large mental hospital, which not infrequently contains younger patients, and five Child Guidance Clinics.

I am glad to say that the second peripatetic teacher of the deaf has been appointed to help in the teaching of deaf children, and with so much goodwill from my colleagues, the otologists, extensions of joint clinics — assessment and treatment clinics — are slowly but surely gaining ground.

The handicapped school leavers still present a problem, as will be seen from the pages of this report, but the development of the twice yearly handicapped school leavers conference marks an attainment and an improvement in taking adult care of these persons who, more and more, will be coming to live in the community under community care.

At the end of a year which is marked with such progress, discussions were being started on the location of children's specialist clinics; whether these should be in the new hospital or should continue as previously in the local education and health authority premises. There are, naturally, points on both sides and it will be interesting to see where the clinics ultimately do take place.

Lastly, the School Dental Service, of which this northern authority can be so proud, continues to show new developments.

One of the dentists is associated now more firmly with the consultant orthodontist in his hospital work, and another one is undertaking research of no small moment associated with dental caries, thanks to the great help of the Education Department and the Atomic Energy Authority.

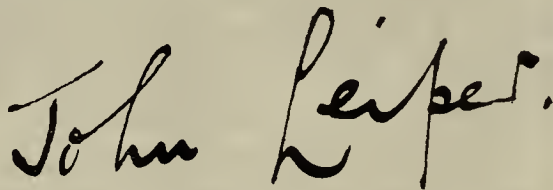
Much co-operation and help has been available during the year from Dr. J. W. Platt, Consultant Paediatrician for the area, and I am glad to say that shortly a further consultant paediatrician will be appointed in the East Cumberland area.

From my colleagues in general practice and hospital practice I have once again received all the help which one colleague can ask of another. I wish to thank them.

I wish to thank all who helped in the preparation of this report, especially my deputy, Dr. J. D. Terrell. Again, the high standard of work of all members of the Health and Welfare Department continues to be invaluable.

I am, Mr. Chairman, Ladies and Gentlemen,

Your obedient servant,

A handwritten signature in cursive script that reads "John Leiper". The signature is written in dark ink and is positioned above the typed name and title.

Principal School Medical Officer.

County Health Department,
11 Portland Square,
Carlisle.
May, 1965.

SCHOOL HEALTH SERVICE

STAFF AS AT 31.12.64

SCHOOL MEDICAL AND DENTAL STAFF

Principal School Medical Officer—

*J. Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S.,
L.R.C.P., D.P.H.

Deputy Principal School Medical Officer—

*J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H. (also
Northern Area Medical Officer).

School Medical Officers—

A. Crowley, M.B., B.Ch., D.Obst.R.C.O.G., D.P.H.

*J. N. Dobson, M.B., Ch.B., D.P.H. (Southern Area
Medical Officer).

J. R. Hassan, M.B., Ch.B., D.Obst.R.C.O.G. (Part-time—
General Practitioner).

*J. L. Hunter, M.B., Ch.B., D.P.H. (Western Area Medical
Officer).

*J. Patterson, M.B., B.Ch., B.A.O., D.P.H.

*H. C. T. Smith, M.B., Ch.B., D.P.H., D.P.A.

*K. J. Thomson, M.B., Ch.B., D.P.H., L.M.

The above are also District Medical Officers of Health and

Assistant School Medical Officers.

*J. E. Ainsworth, M.B., Ch.B.

*E. M. O. Campbell, M.B., Ch.B., D.P.H., D.T.M. & H.

*E. M. Spencer, M.B., Ch.B.

*M. Timperley, M.B., Ch.B.

*Approved for the ascertainment of educationally sub-
normal pupils.

Principal School Dental Officer—

R. B. Neal, M.B.E., T.D., L.D.S.R.C.S.

Area School Dental Officer—

R. C. Crabb, L.D.S.R.F.P.S.

School Dental Officers—

J. A. G. Baxter, L.D.S.R.C.S.
M. Green, L.D.S.R.C.S.
D. H. Hayes, L.D.S. Resigned 31.10.64.
M. Hayes, B.D.S. Resigned 30.11.64.
F. H. Jacobs, L.D.S.
I. H. Parsons, L.D.S.
A. R. Peck, L.D.S.
J. G. Potter, L.D.S.R.F.P.S. Resigned 12.4.64.
A. M. Scott, L.D.S.

MEDICAL AUXILIARY STAFF

Audiometricians—

Mrs. M. G. Hicks.
Mrs. R. Gaughy. Resigned 11.9.64.
Miss M. Matthews. Commenced 1.9.64.

Orthopaedic Physiotherapists—

Miss J. A. Fraser, M.C.S.P., O.N.C.
Miss J. M. Morris, M.C.S.P.

Orthoptists—

Mrs. G. M. Richardson, D.B.O. (Part-time).

Speech Therapists—

Mrs. E. M. Blacklock, L.C.S.T.
Miss E. B. Moon, L.C.S.T. (Part-time).
Mrs. S. Latimer, L.C.S.T. (Part-time).
Mrs. M. V. Aitchison, L.C.S.T. (Part-time).

NURSING STAFF

Superintendent Nursing Officer—

Miss I. Mansbridge, M.B.E., S.R.N., S.C.M., Q.N.,
H.V.Cert.

Deputy Superintendent Nursing Officer—

Miss M. Blockey, S.R.N., R.S.C.N., S.C.M., Q.N.,
H.V.Cert.

Area Nursing Officers—

Miss J. Reid, S.R.N., S.C.M., Q.N., H.V.Cert. (Southern
Area).

Mrs. A. Steele, S.R.N., S.C.M., Q.N., H.V.Cert.
(Western Area).

Miss M. G. M. Watson, S.R.N., S.C.M., Q.N., H.V.Cert.,
R.F.N. (Northern Area).

NURSES QUALIFICATIONS CODE

1. State Registered Nurse (or Registered General Nurse).
2. State Certified Midwife.
3. Queen's Nurse.
4. Health Visitors Certificate.
5. Registered Fever Nurse.
6. State Enrolled Nurse.
7. Registered Sick Children's Nurse.
8. Orthopaedic Nursing Certificate.
9. Diploma in Tropical Nursing.

School Nurses—

Full-time—

Mrs. E. M. Maguire, 1, 2, 8
Mrs. M. E. Sansom, 1, 2, 5
Mrs. B. F. Wilson, 1
Miss D. Wise, 1, 2, 3, 5, 9

Whitehaven
Relief
Whitehaven
Workington

Health Visitors/School Nurses—

NORTHERN AREA

Miss A. Dixon, 1, 2, 4
Miss B. W. Knibbs, 1, 2, 3, 4
Mrs. A. W. E. Maughan, 1, 2, 4
Miss E. Mercer, 1, 2, 4, 5
Miss A. W. Prior, 1, 2, 4, 9
Mrs. M. C. Roberts, 1, 2, 4

Penrith
Brampton
Penrith
Wigton & Silloth
Longtown
Aspatria

WESTERN AREA

Miss G. Davies, 1, 3, 4
Mrs. B. L. Goodson, 1, 2, 4
Mrs. M. Hewitson, 1, 2, 4
Miss M. Horn, 1, 2, 4, 5
Miss A. Jackson, 1, 2, 4
Miss F. Kendall, 1, 2, 4
Miss J. E. Surtees, 1, 2, 4
Miss S. Twigg, 1, 2, 3, 4

Workington
Workington
Workington
Cockermouth
Workington
Maryport
Workington
Maryport

SOUTHERN AREA

Miss I. M. Alcock, 1, 2, 4	Whitehaven
Mrs. S. Crellin, 1, 2, 4	Whitehaven
Miss E. Crosby, 1, 2, 4	Egremont
Miss A. M. Little, 1, 2, 4	Millom
Miss R. A. Lodge, 1, 2, 4	Whitehaven
Mrs. A. Petch, 1, 2, 3, 4	Whitehaven
Miss R. Sheppard, 1, 2, 3, 4	Cleator Moor
Miss P. Walsh, 1, 2, 4	Egremont
All the above health visitors/school nurses are seconded to general practitioners.	

School Nurses—

Part-time—

NORTHERN AREA

Miss I. Arnott, 1, 2, 3, 8	Threlkeld
Miss M. A. Barclay, 1, 2, 3, 5	Greystoke
Miss A. Bowler, 1, 2, 3, 4	Caldbeck
Miss J. R. N. Byres, 1, 2, 3, 5	High Hesket
Miss E. M. Chalkley, 1, 2, 3, 4	Langwathby
Miss A. A. Cockton, 1, 2, 3, 5	Burgh-by-Sands
Mrs. M. Dobson, 1, 2, 3, 4	Houghton
Miss L. R. Douglass, 2, 6	Skelton
*Mrs. F. A. Gaskin, 1, 2, 3	Irthington
Miss C. H. Greaves, 1, 2, 3	Lazonby
Mrs. M. Hedworth, 1, 2, 3	Abbeytown
Miss E. Henderson, 1, 2, 3	Langwathby
Mrs. D. M. Lancaster, 1, 2, 3, 4	Wigton
Mrs. M. J. Mathews, 1, 2, 3, 4	Watermillock
*Miss F. M. McGrath, 1, 2, 3	Dalston
Miss A. M. M. Penman, 1, 2, 3, 4	Thursby
Mrs. E. E. Rome, 2, 6	Kirkbride
Miss N. D. Sanderson, 1, 2, 3, 4	Bewcastle
Miss P. B. Simpson, 1, 2, 3, 4	Wigton
Miss E. M. Wallace, 1, 2, 3	Wetheral
Miss M. Weightman, 1, 2, 3	Scotby
*Miss B. M. Wesson, 1, 2, 3	Hayton

WESTERN AREA

Miss M. Casey, 1, 2, 3, 4	Keswick
Mrs. A. Donald, 1, 2, 3, 4, 7	Oughterside
Miss S. J. Graham, 2, 6	Brigham
Miss A. M. Greggain, 1, 2, 3, 4	Bassenthwaite
Miss J. M. Hillhouse, 1, 2	Keswick

Miss R. Hobbiss, 1, 2, 3, 4	Lorton
Mrs. N. Hodgson, 2, 6	Broughton
Miss S. M. J. Iliffe, 1, 2, 3	Borrowdale
Miss C. F. M. McKnight, 1, 2, 3, 4	Dearham
Miss R. W. Ventress, 1, 2, 3, 4	Bothel

SOUTHERN AREA

Mrs. I. E. Bowe, 1, 2, 3, 4	Bootle
Mrs. J. A. Graham, 1, 2, 3, 4	Distington
*Miss C. O. Grosvenor, 1, 2, 3, 4	Millom
Miss J. A. G. Hardie, 1, 2, 3, 4	Parton
Miss D. D. James, 1, 2, 3, 4	Seascale
Mrs. M. Marshall, 1, 2, 3	Muncaster
*Miss A. M. Mackay, 1, 2, 3, 4	Lamplugh

*Seconded to General Practitioners.

Dental Surgery Assistants—

Miss O. Bird	Miss E. A. Parmley
Mrs. M. Byers	Mrs. W. F. Reeves
Mrs. E. Hocking	Mrs. B. H. Robinson
Mrs. S. F. Kerr	Mrs. C. Smart
Mrs. J. G. Nicholson	Miss M. I. Stout

GENERAL STATISTICS

The area covered by the Local Education Authority comprises 967,054 acres and the estimated population of the Administrative County in June, 1964, was 225,690.

The number of pupils on the school registers in January, 1965, was 38,553, compared with 38,405 in the previous year, an increase of 148.

In January, 1965, there were in the county:—

		No. of pupils
Nursery school	... .. 1	40
Primary schools	... .. 244	22,812
Non-selective secondary schools	... .. 24	9,581
Grammar schools	... .. 10	5,716
Secondary Technical schools	... .. 1	310
Residential special schools	... .. 2	
(One for educationally subnormal boys, age range 9-16 years)	... ..	56
(One for educationally subnormal girls, age range 9-16 years)	... ..	38
		<hr/> 38,553 <hr/>

THE PATTERN AND DEVELOPMENT OF THE SERVICE

Administration

Without doubt the most important change in the general pattern of the School Health Service in 1964 was the establishment of area administration involving three Area Health committees dealing with all health department day to day functions, including school health, and delegating to the area medical officers a full and wide responsibility for the administration of services.

As foreshadowed in last year's report, the Area Health committees have the benefit of the presence as members of the teacher representatives from the corresponding Area Education Committee. It is already apparent that the more concentrated local representation on the Area Health committees is being reflected to general advantage in the discussions and recommendations which are coming from them.

The Northern Area consists of the rural districts of Alston, Border, Penrith and Wigton, and the urban district of Penrith. Within this area there are 127 schools and a total of about 12,250 pupils. Dr. J. D. Terrell, the Deputy Principal School Medical Officer, is acting as Northern Area Medical Officer under a temporary arrangement.

The borough of Workington, the rural district of Cocker-mouth and the urban districts of Cocker-mouth, Keswick and Maryport form the Western Area which has Dr. J. L. Hunter as Area Medical Officer. The eighty-three schools in the area have about 12,750 pupils.

In the Southern Area, which covers the borough of Whitehaven and the rural districts of Ennerdale and Millom, there are 13,500 pupils attending sixty-eight schools. The Area Medical Officer is Dr. J. N. Dobson.

At officer level similar advantages are being found and the staff of the School Health Service have settled well and enthusiastically into the new system. It gives distinct promise of aiding significantly the still closer integration of school health with other health and welfare services, as well, of course, as with the education service itself. Examples of this developing

integration will be found elsewhere in this report, notably with regard to handicapped school leavers.

Linking closely with all of the work of the service is the function of the reconstructed Joint Health and Education Sub-Committee which had its first meeting before the end of the year. A wide range of interest was represented on the agenda, e.g., institution of a scholarship scheme for orthoptists, pasteurised milk supplies in schools, classes for handicapped pupils, proposals to extend School Psychological Service, recruitment of speech therapists, etc.

As a policy-making committee in anticipation of both Health and Education Committees, it is my intention and also that of the Director of Education that this body shall be given every opportunity of making a very important contribution on the inter-sections in the spheres of Education and Health/Welfare.

The continuance of the "At Risk" Register and the Register of Congenital Abnormalities is stream-lining the documentation of handicapped children from birth and helping to produce a more comprehensive picture of the child at an earlier stage. The advantages of this in the forward educational planning for handicapped children are obvious.

I am indebted to Dr. K. J. Thomson for the following interesting report on his work in Cumberland since 1936, particularly in relation to the changes which have taken place in the approach to the preventive aspect of the School Health Service:—

"When I was first appointed in 1936 as full-time Assistant County Medical Officer of Health I worked in West Cumberland where there had been a period of acute depression for many years previously. Comparing these early days of my service with present day conditions, my chief impression is the change from active clinical medicine with definite treatment carried out in clinics, whereas today practically no treatment is done and, in fact, there are no school clinics as such. It must be appreciated that prior to 1948, when the National Health Service became operative, there was no National Health Service available except to insured workers, the families of such insured people being considered as private patients and it cost money to consult the doctor for treatment of wives and families.

“ Very little money was available in the days of 1936 and onwards until after the commencement of the second world war in 1939, when the financial position of most families improved enormously. It is a strange reflection of modern times that total war was required to bring about improvement in general medical services and, particularly, in nutritional standards. As a result of rationing introduced in war-time, the nutritional level of the whole nation improved remarkably and families in the low income group were forced to spend their money to better advantage. National dried milk for babies was introduced together with orange juice and cod liver oil which gave a much more balanced diet to babies than previously existed. Although these additions to diet have continued to the present day, it is unfortunate that there has been a falling off in the take up of these necessary vitamins. Nevertheless, on the whole the health of the young pre-school and school child has improved greatly.

“ In my early days in West Cumberland the school clinics were extremely busy and one dealt with hundreds of cases of all types, chief among them being skin diseases—impetigo, scabies and head infestations. Discharging ears were a perfect headache in that they continued attending for months and months without any improvement and frequently resulted in acute surgical emergencies, e.g., cerebral abscess or meningitis. Such cases were dealt with at the clinics and admittance to hospital was arranged directly between the clinic and hospital with subsequent reference to the G.P. concerned. Tonsils and adenoid cases were admitted to the waiting list without prior consultation with the Specialist, a state of affairs which would not now be considered and, I think, rightly so. It is quite astonishing to me to report that enlarged tonsils which I would previously have considered required operative treatment disappear without any operation whatever.

“ Chest cases also caused a great deal of worry, particularly contacts of tuberculosis cases and bronchiectasis. Indeed, it was during my time in West Cumberland that special notice was taken of this latter type of case and special investigation of such cases was carried out under the direction of Mr. Mason, Chief Surgeon at Shotley Bridge Hospital. Orthopaedic cases in children were another acute problem, and special clinics and investigation of such cases was instituted and necessary treatment carried out.

"Looking at present day conditions of the health of the school child, I am impressed by the change from active clinical treatment to the importance now laid on the preventive aspect of health and this is, undoubtedly, the most important change that has occurred in my twenty-eight years of service with the County. The early detection of congenital heart conditions with subsequent treatment has been an important feature of our present day school service. I feel also that the detection of the mentally affected or psychologically disturbed school child has improved enormously in the past ten years and that our awareness of such cases has shown a great advance in recent years.

"The School Health Service carries out regular examination of all children by an audiometrician visiting schools to carry out hearing tests in the younger age group. Much more regular investigation is now carried out with reference to finding out educationally subnormal children. I would here express the opinion that although we find out these educationally subnormal children, unfortunately there is not sufficient accommodation at present in the way of special schools to deal with such cases.

"In the past three to four years inoculation against tetanus has been introduced and has involved a great deal of additional work, particularly with regard to the older age groups. In due course, however, this problem will solve itself as most babies now are injected with the triple antigen in early infancy.

"Speech defects have also been considered an important aspect of the School Health Service and I feel that a greater awareness of this condition has developed in the past few years but, unfortunately, speech therapists are difficult to find.

"Dr. Leiper, the Principal School Medical Officer, has initiated many changes with particular reference to the preventive aspect of the School Health Service and, as an 'old stager,' I would like to congratulate him on these changes and improvements."

The following commentary by the Headmistress of an Infants' School, who is also a member of the Joint Sub Health

and Education Committee, is particularly encouraging, and I am grateful to Miss M. I. Wandless:—

“ At a time when education is properly regarded as the all-round growth or development of the child, it is not surprising to find a growing desire for closer understanding and co-operation between all who influence him — parents, teachers, nurses, doctors, administrators and others. As mental capacity, emotional states and physical maladies are closely connected, experts can no longer work effectively in isolation; each is now more conscious of the contribution of the other to the state of robust health which we desire for our children.

“ The infants' school grows out of the regime of home life, and becomes an extension of it. Midwives, health visitors, school nurses and trips to clinics are a familiar and accepted part of the child's life. At this early stage, teachers draw readily on the health visitors' knowledge of the homes and background of the pupils; later teachers become the 'eyes' and 'ears' of the School Health Service and the child is 'screened' throughout his school life. Thus, the more obvious physical and mental defects, and any falling away from reasonable standards of cleanliness receive early and constant attention. Less obvious, and possibly more serious defects are revealed by the medical officer's examination (roughly at 5, 8, 11 and 14 years of age). Some teachers are concerned about the length of the time lapse between inspections, believing that abnormalities might develop which only the doctor's skill can detect. Fortunately parents are becoming increasingly more 'health' conscious, more aware of the services at their disposal, and less suspicious of them, but there still remains the child from the less fortunate home. Are his hidden defects likely to be diagnosed in time for early and preventive treatment?

“ Children with known defects, be they of vision, hearing, speech, teeth or other bodily ills, and those suffering from emotional upsets, such as bed wetting and behaviour problems, are examined and treated by medical officers and consultants in the school clinics, and if complete cure is not possible at least the fault is kept in check. The schools supply reports and help the children to carry out the doctor's instructions regarding the use of spectacles, hearing aids, calipers, etc.

“ Gone are the days when a child with learning difficulties was labelled 'stupid' and abandoned, or when a naughty or

difficult child was subjected to corporal punishment. A teacher realises when the condition of the child falls outside his own expert knowledge and, after consulting with parents, he seeks positive help and guidance from the educational psychologist. Maladjustments receive enlightened attention early, otherwise they become deep rooted and permanent, and not only does the child's school performance deteriorate, but also his capacity for living, and he may become a menace to society. This rapid living, highly organised, and materially affluent age produces many breakdowns and misfits or problem children. There is no doubt among the teachers that many of these difficulties could be resolved by expert treatment in the very early stages (i.e., at infant school level). Most teachers acquire a wide knowledge of normal children and the earlier any deviation is noticed, the better the chance under skilful treatment, of a return to normal. There is a very real need for an extension of this service, and also for greater ease of communication between parents, doctors, educational psychologists, teachers and nurses. The progress units which are to be established in some primary schools in the near future may help to bridge this gap.

“What of the future? We hope that in our larger schools, and especially in the larger primary schools (the junior ‘comprehensives’), we may soon have suitably qualified matrons among our non-teaching ancillary staff (and a group of small schools might effectively share a matron). With teachers, nurses and doctors in short supply, and the National Health Service in a state of flux, and with the building of a magnificent hospital in our midst, it is possible that the warm and essentially human links of home, school and clinic may be partially sacrificed on the altars of convenience, economics and centralisation. It has taken years of patient, efficient and devoted service to build up the School Health Service, which now has the confidence and goodwill of the parents and schools. Rather let us bring it even nearer to the home by adding clinics and mothers’ rooms to our infants’ schools—but this, of course, is fantasy — and is, indeed, for the future!”

Medical Examinations

Selective medical examination of school children has not yet been extended from the southern area to either the west or

the north. Apart from the fact that medical staffing difficulties have prevented the complete effectiveness of the scheme in the southern area as planned, and thus its evaluation is imperfect, the introduction of area administration has rather overshadowed other possible changes. I hope to decide in 1965 about the extension of selective medical examinations in the other two areas of the county.

A full year has passed now, however, during which selective medical examination has been practised in the southern area, consisting of the examination of full entrant and leaver groups, but the substitution of a selective procedure including a questionnaire at the ages of 8 and 12 as replacing the previous ten-year-old routine medical examinations. The table "A" in Appendix "A," page 103, merits some study in this connection. Three routine medical examinations in school life produce three "bulges" in the numbers examined in the years of school life, shown on the table. Now with the introduction of a selective procedure at 8 and 12 for one-third of the school population, new and smaller "bulges" appear in the corresponding year groups — the latter in this instance are the years 1956 and 1952. It will be seen from this table that of just over 1,200 children "screened" by selective procedures, 45% were "selected in" for medical examination in the 1956 year group (8 year olds), while of just over 1,000 in the 1952 year group (12 year olds), 49%, almost exactly half, were "selected in" for medical examination. This figure becomes significant when the total individual pupils found to require treatment is studied, for these selective procedures are producing 11% in the 8 year old age group and almost 10% in the 12 year old age group. This is, however, from a selected group and the proportions found requiring treatment will require to be carefully watched as the scheme progresses. One would expect a somewhat higher proportion requiring treatment from a selected group of children in order to be quite sure that those not selected for medical examination were not concealing conditions which might have been found through a non-selective procedure. A further analysis is being undertaken of the types of defects found at selective and non-selective examinations in order to show whether any particular conditions are specially liable to be missed. Such considerations of the outcome of the selective procedure are essential if

one is to be certain that the widened opportunity of parents and teachers to refer children is being utilised to the full and proving effective. I know that Dr. J. N. Dobson, who has supervised the selective medical examination in the southern area, has this and many other points under study, and I give below his comments on the service in 1964:—

“ A trial of the system commenced in the southern area in the second and third school terms of 1963, was described at some length in the 1963 Annual Report. The scheme continued in 1964 and continues to be preferred from a medical point of view though, as noted before, demands on medical officer time are increased rather than diminished and the work for clerical staff is substantially greater.

“ The medical officers concerned share the view, found in most local authority areas which have publicised their experiences, that relations with school staffs are improved and that there is a better interchange of information. This can be only to the benefit of the school child. Some critics have claimed the impossibility of showing that the number of significant defects found is no fewer than under the old system of universal inspection. Attempts by some authorities at controlled trials, where selective examination has been followed by examination of all the other pupils in the same year group for comparison, have not been wholly convincing owing, for example, to the intensive preparation of teachers and parents for the trial, unusual zeal in recovering the questionnaires distributed, and the enthusiasm of examiners facing a challenge.

“ To be successful, selective inspection must be an improvement on its predecessors when practised by the ‘average’ medical officer dealing with ‘average’ parents and ‘average’ teachers. It is the more pleasing to record that the medical officers in this area accepted the changed procedure with an open mind and continue to favour its use. Unless the harvest of defects is well above or below that found in earlier years it is difficult to assess its merits statistically, and that is, indeed, the position. No doubt some conditions will be missed but, for that matter, so must they have been under the older system.

“ What, perhaps, is less easy to justify than selective inspection is any return now to mass inspection of what is

substantially a healthy school community. The general principle in preventive medicine of concentrating on 'at risk' groups and screening techniques is firmly established and will be used increasingly. Selective school medical inspection exemplifies this more purposeful approach to the detection of deviations from normal health.

"It may be of interest to refer to the form of questionnaire currently in use. The aim should be to get a useful guide to the child's health, comprehensive, but capable of rapid assessment by the examiner. It should be comprehensible by, and acceptable to, all parents.

"With these points in view the form now in use was arrived at and a specimen is included in Appendix 'D.' Words previously used but not familiar to all parents were omitted, e.g., 'isolated' and 'abnormal.' The form is used for both selective and routine periodic examinations.

Generally it has been well received and completed satisfactorily to give a fair indication of the need for medical examination but, as has already been remarked, the doctor-teacher discussion, before finally deciding not to see children not selected by the doctor is a vital part of the scheme."

Dr. A. Crowley writes from Millom:—

"The year 1964 was the first complete year in which selective examinations were used. The examinations proceeded quite smoothly and were, in my opinion, more valuable than the previous unselected type of examination. There was much freer exchange of information between the teachers, parents and medical staff, although the necessity for two visits to each school made the process that much more difficult to carry out.

"The most common items discovered on examination were: eye defects and minor orthopaedic disabilities. The matter most frequently brought forward by the teachers and parents were usually: backwardness, hearing defects, and speech defects. The most difficult conditions to deal with were the cases of mental disturbance, whilst the absence of a speech therapist in the area was felt to be a great loss."

I am very glad to quote the following comments by Dr. E. M. Spencer:—

“ The new scheme of selective school medical inspection proceeded as planned in the southern area in 1964 but was rather hampered by a shortage of medical officers.

“ Many of the initial problems of the previous year were eliminated as everyone concerned became more familiar with the ideas and aims of the system.

“ Some of the head teachers, especially in the poorer areas where more poverty and illness prevailed, were less satisfied. They felt that theirs was too great a responsibility, i.e., to bring forward children in need of medical attention arising after the five year old examination, and they preferred the old system where every child was examined at 9-10 years of age. I think it would be fair comment to say that this burden weighs more heavily on the teachers in these areas.

“ It is difficult to assess how the two types of school medical inspections compare from the point of view of finding defects. However, from my point of view, one feels much more at home in a school one visits each term and a more friendly atmosphere seems to prevail. One certainly gets to know better the children in need of medical or social attention. Two such cases spring readily to mind:—

“ (1) A child with very poor speech, believed to be deaf and recently given a hearing aid. The ear, nose and throat specialist wishes her to stay in the ordinary school and I am able to visit the school nearly every week regularly to give help, advice and support to the teaching staff, as well as to assess the child's progress.

“ (2) Two children, whose mother has died, and who are often tired in school and whose rather thin condition causes general concern.

“ These are samples of problems which can be kept under constant informal review much more easily with the selective method of school medical inspection.

“ The general health of children in South Cumberland continues to be very good and every effort is being made to educate children to try and promote good health in themselves

and those dependent upon them. The nursing staff run formal courses of instruction in Health Education in many of the schools and I talk more informally wherever possible during the inspections."

One problem which is increasingly exercising all concerned with child health today, is that of over-feeding, and it is a somewhat wry comment on many advances in child health. Dr. J. E. Ainsworth, Assistant School Medical Officer in the Western Area, has taken a particular interest in this subject during 1964 and I quote below her comments:—

"During this last school year I have been specially interested in obesity in school children. I have found it unusual to advise a mother about an undernourished child, but it is certainly not unusual to have to advise about overweight. I think this will be a growing problem with better incomes, hence improved diet and standard of living, and will be a more prominent problem of the future.

"Diet seems a main aetiological factor in these obese children and not all take one's advice after being seen only once at school medical inspection. I wonder if a special session once per month or once per two months to follow up these overweight children would be useful and interesting. Miss Surtees, Health Visitor to Drs. McKerrow, Sime and Rutherford, in Workington, is also interested in the same subject and is starting a clinic in Dr. Rutherford's surgery for patients of all age groups attached to the practice only.

"It would be interesting to categorise the obese children for weight, age groups, number in family, social and income level. Also emotional factors could be revealed as a cause and physical disease, e.g., hypopituitarism, endocrine disorders, etc. Urine tests could be carried out routinely and calorific intake advised upon.

"One finds knock-knees and flat feet are often associated with obesity, e.g., at one secondary modern school two out of four obese children had flat feet and knock-knees.

"I think the school tuck shops do not improve the situation—the headmistress of one school in which there were eleven overweight children told me that the tuck shop 'does a roaring

trade,' that they have stopped selling biscuits for dental reasons, but now they mainly sell crisps!

"The headmistress of Lillyhall Secondary Modern School, Distington, kindly co-operated and weighed the obese children and supervised their diet for one term following the school medical inspection, with the result that five lost some weight and others were controlled. Since regular weighing ceased, nine out of the eleven have gained weight by 18.1.65."

The School Nurse and Hygiene Inspection

If we ask ourselves what is the most important duty of the school nurse, many would say the work they do during the routine hygiene inspections in schools. The value of this work by school nurses cannot be over-emphasised; not only does it bring to light conditions of uncleanness in children during the regular inspections at school, but also gives the nurses a real and personal contact with the parents.

The health educational work of the nurses among parents continues to be the most important factor in reducing the incidence of uncleanness. A school nurse reports:—"New entrants have nearly all been clean and free from infestation. I think this is due to young mothers attending child welfare clinics and taking pride in their children."

In 1963 the number of children found to be infested was 1,419, a higher figure than had been recorded since 1960. This year, 1964, the figure has dropped to 1,204, the lowest figure since 1959. This is a decrease of 15% compared with 1963. The total number of examinations has increased from 95,817 in 1963 to 117,583 in 1964 — an increase of 22%. These are pleasing results and, perhaps, when the hair style of boys changes fashion these figures will be again reduced.

Year	No. of examinations	No. of children found infested
1964	117,583	1,204
1963	95,817	1,419
1962	69,439	1,406
1961	79,007	1,269
1960	72,226	1,531

In many cases school children are reinfested from other members of the family, perhaps the mother, grandmother or

older sisters, and it is with this in mind that the health visitor/school nurse follows up all children found to be infested by a home visit.

The number of home visits made by all health visitors/school nurses in 1964 was 1,134. This number of home visits alone will not reduce the number of school children infested with pediculosis capitis; critical is the ability of the health visitor/school nurse to gain the co-operation of all members of the family. Firstly, the parents must learn to accept the fact that their child's head is affected, then the nurse must try to change the attitude of some parents and children who still feel that this is normal; and, finally, the parents must be persuaded to accept treatment for the condition.

Here I quote the observations of one school nurse—"Home visits are still very important and we appear to be doing many more not only for infestation, but follow-up visits after school medicals, especially if the parent does not attend when the child is examined, and doctor would like them to attend school clinic."

Progress towards the elimination of infestation in the population is still slow and one wonders if complete elimination will ever be achieved. One can only hope that with supervision, persuasion and health education, the ideal will be approached.

In a semi-rural area a health visitor/school nurse reports:—"There is very little uncleanliness in this area, the main problem appears to be flat feet and other foot hygiene problems. One wonders if the frequent use of Wellingtons is partly responsible.

"Other conditions found at hygiene inspections have been a deaf child, due to frequent colds; dental caries; dirty teeth; children with squints, not wearing glasses; children walking badly and later referred to the orthopaedic clinics."

The school attendance and welfare officers and the school nurses work very closely together and, as a result, shoes have been provided by the Education Department to needy cases. The W.V.S. have also helped with the issuing of clothes.

Teachers frequently refer children to the nurse whom they feel would benefit by a holiday at Allonby children's holiday

home. The nurse then visits the parents and has often to persuade reluctant parents to allow the child to have a fortnight's holiday at the seaside.

An anxious mother wanted to talk to someone about her little boy who, she discovered, was stealing, and she confided in the school nurse. This problem was referred through the usual channels to the child guidance clinic.

In an urban area a nurse reports:—"The opening of a new factory has made its mark on the school children. More mothers are now going out to work with the result that their children are not so well clad and there are many more behaviour problems. Mothers are not attending the school medical examinations with their children."

Another report from an urban area states:—"It is amazing to find that some children are still unaware of the presence of nits and lice in their hair and, indeed, know nothing about them. Doing a home visit to a very aggressive unemployed father, the only thought that moved him was that the lice were living on his child's blood. That was enough — no one and nothing was going to get anything out of him or his family! The child's head was clean from that day forth."

One *mother* was found to have defective vision when a home visit was paid; the nurse soon referred the mother for glasses and she has been a much happier person since!

Dental care is still a problem; children often appear with notes from their parents saying that they wish their child to have private dental treatment. When a home visit is paid, the nurse finds that this is just an excuse. One wonders if children can influence their parents even against themselves and their own interests.

The school nurse's work would be almost impossible without the help and co-operation of all teaching staff. A school nurse reports:—"We have had excellent co-operation from all teaching staff in the schools. We are contacted by them regarding children they find in school with behaviour problems, physical conditions and infestation and neglected and poorly clad — these being in the minority."

In spite of a still high figure for school children infested, I feel that the time is approaching for serious consideration to be given to a phased reduction in general "head inspections" in school. Many schools seldom or never produce serious trouble. Those which do because of the presence of representatives of families unsatisfactory in this respect, will obviously continue to require a judicious and careful watch. I shall be discussing this whole question more fully with the nursing staff in the course of 1965.

Employment of Children Bye-Laws.

The figures below show the numbers of children examined during the year in accordance with the above bye-laws. None of the children examined were found to be unsatisfactory.

Total examined during the year ...	...	189
Total number of children involved	...	181
Examined for the first time	Re-examined once	Re-examined twice
177	12	Nil

School Clinic Work

Children may be referred for school clinic type consultations with the school medical officer at any of 27 situations in the county. Flatt Walks, Whitehaven, and Park Lane, Workington, continue to be the only two clinics at which formal school clinic sessions are regularly held and no serious difficulty appears to be emerging from the arrangement whereby at other centres *ad hoc* arrangements are made for individual children or groups of children as required. The numbers attending show a further slight decline this year, except in the matter of ear conditions, as will be seen in the table on page 31. This reflects increasing audiometric screening of school children and the subsequent examination at a clinic of those thought to be suffering from impaired hearing. This point is dealt with more fully under the heading of audiology services.

Salterbeck Clinic, Workington, came into use during the autumn of 1964 and represents the first of a series of small satellite clinics of which there will be a further ten appearing in different parts of the county in the course of the next ten years. School health service functions are only part of the use of such buildings, but an extremely important part, especially

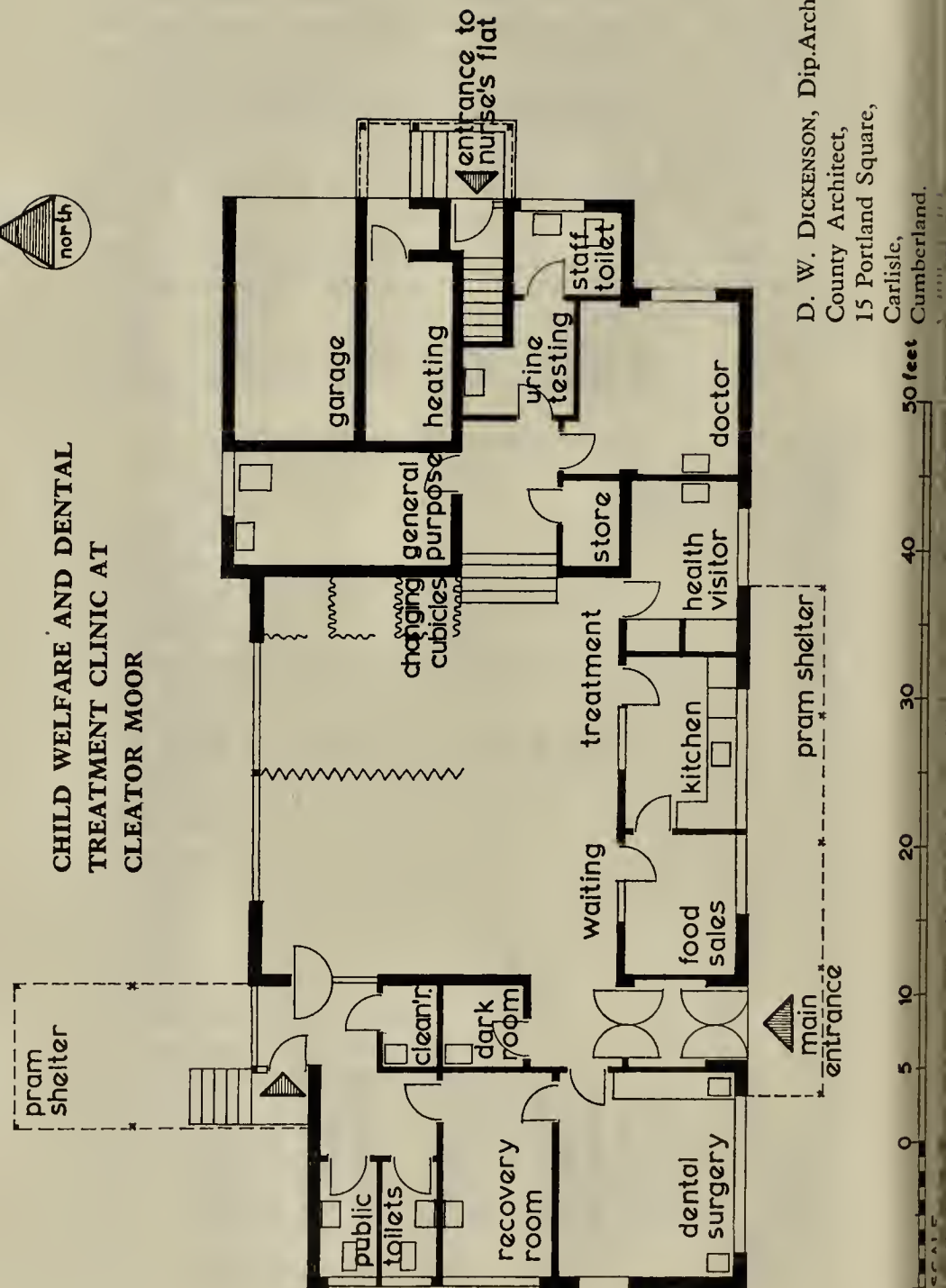
when it is considered how useful they will be for carrying out such examinations as hearing and vision tests on both school and pre-school children and, of course, in the provision of comprehensive and more local dental services for children and expectant and nursing mothers. The use was discontinued of two very unsatisfactory premises during the year, used mainly it is true for child welfare services but also to some extent for school clinic work. This was associated with the bringing into use of Salterbeck Clinic and illustrates the vastly improved facilities which such clinics will provide for school and pre-school children in the future. The next clinic planned, for Cleator Moor, has several new features incorporated, including a loop system to facilitate deaf children and adults using hearing aids. Improved projection facilities have also been included in the plans for health education purposes.

Clinic	New Cases	Total Attend- ances
Anthorn	3	3
Aspatria	51	143
Brampton	27	38
Cleator Moor	14	19
Cockermouth	70	88
Egremont	29	45
Frizington	3	4
Houghton	7	7
Keswick	6	18
Longtown	3	3
Maryport	33	75
Millom	29	36
Penrith	16	17
Scotby	2	2
Wetheral	1	1
Whitehaven (Mirehouse)	9	13
Whitehaven (Flatt Walks)	98	133
Whitehaven (Woodhouse)	1	1
Wigton	70	78
Workington	117	321
	<hr/> 589	<hr/> 1045

SCHOOL CLINICS

Defect Code No.	Conditions for which child attended	New Cases					Total Attendances							
		1964	1963	1962	1961	1960	1959	1964	1963	1962	1961	1960	1959	
1.	Cleanliness	...	1	11	—	1	5	1	1	16	—	7	16	6
2.	Infestation	...	17	2	—	6	51	38	34	2	—	13	126	146
4.	Skin diseases	...	88	147	597	524	827	628	195	408	1891	1867	2906	2448
5.	Eye diseases	...	145	169	303	298	270	352	186	316	729	698	855	1109
6.	Ear conditions	...	110	78	64	63	72	99	163	105	213	233	247	356
7.	Nose and throat conditions	...	25	44	50	37	55	78	53	68	80	77	128	143
8.	Speech defects	...	17	21	34	22	25	20	19	22	43	26	34	25
9.	Lymphatic glands	...	—	3	16	3	3	6	—	4	21	7	5	10
10.	Heart	...	1	3	2	2	5	4	1	3	11	4	17	10
11.	Lungs	...	6	18	37	23	21	44	6	26	358	51	97	232
12.	Developmental	...	2	2	6	2	1	3	3	5	13	8	9	7
13.	Orthopaedic	...	36	46	105	35	84	110	47	48	165	54	132	196
14.	Nervous system	...	20	2	5	7	19	24	70	3	32	12	256	156
15.	Psychological	...	13	12	25	16	15	16	21	17	45	29	34	35
16.	Abdomen	...	5	13	15	5	17	6	9	16	25	8	40	16
17.	Other conditions	...	103	103	244	356	732	735	237	188	541	856	1826	1828
		589	674	1503	1400	2202	2164	1045	1247	4167	3950	6728	6723	

CHILD WELFARE AND DENTAL TREATMENT CLINIC AT CLEATOR MOOR



D. W. DICKENSON, Dip.Arch., F.R.I.B.A.,
County Architect,
15 Portland Square,
Carlisle,
Cumberland.

SPECIAL SERVICES

Towards the end of 1964 it became necessary to look very closely at the pattern of specialist clinics conducted for the School Health Service by consultant staff from the hospitals. Most of these clinics which include ophthalmic, E.N.T., child guidance, orthopaedic work, are carried out in school clinic premises, while a minority are hospital based. There are certain obvious advantages to the consultant staff in conducting these clinics for school children in hospital premises where the maximum of equipment required is available, and there is also a saving in the specialists' time. On the other hand certain misgivings are inescapable in regard to otherwise well children undergoing investigation or even treatment for a single defect, for example, refractive vision error, attending a hospital with all the attendant disadvantages of mingling to greater or lesser degree with sick and injured people. At the time of writing this report discussions are proceeding between the representatives of the Special Area Committee and those of the Joint Sub-Health and Education Committee on this subject and on other related issues which immediately arise when this problem is studied. No doubt a solution to the problem reasonable and acceptable to all will be achieved and, perhaps, at the same time further areas of co-operation between the hospital service, the School Health Service and the general practitioners will be explored to mutual benefit. The part which might be played by school medical officers in the special services in the future will be one such subject. There can be no doubt that the closer both medical and nursing staff working in the School Health Service can draw to their colleagues in hospital and general practice, the more will the advantages of unified health services become apparent and effective.

Ear, Nose and Throat Conditions

The clinics held in Carlisle by Mr. W. J. O. Page, Consultant E.N.T. Surgeon, cater for an average of twelve children at each session. These clinics are held once in three weeks, while those at West Cumberland Hospital are held once every five weeks and cater for a somewhat smaller average number of children. The pattern of work at these clinics has changed considerably over the years and last year Mr. Thomas gave a most interesting account of various aspects of the subject in which

he was especially interested, including the problem of otitis media and the long standing tonsils and adenoids problem. I am most grateful this year to Mr. Page for writing a very comprehensive account of his thoughts on these school clinics as they have increasingly developed into audiology consultations with the surgeons. Mr. Page writes as follows:—

“ This clinic has become a clinic primarily for the deaf child, few cases of upper respiratory and aural infection being dealt with here except in so far as they contribute directly to their deafness.

“ An outline of present-day management of the deaf child and suggested requirements for the future may be of interest to those interested with the welfare of such handicapped children.

“ The majority of deaf children present with only a minor degree of deafness readily eradicated or improved by medical or minimal surgical measures to the point where their handicap will present little in the way of an educational problem.

“ A second group with more marked deafness failing to respond to these simple measures and many of whom would formerly have required education in special schools for the deaf can be assisted with all modern facilities to the point where they can be educated in normal schools with a reasonable prospect of attaining at least average educational levels. With optimum placement in classrooms, provision with hearing aids and instruction in their use, aided by lip reading and speech therapists and, where necessary, by the teachers of the deaf, only a few of this group present major problems.

“ It is with a third and very small group of severely deaf children that our real problem lies. Some twelve of these at present are so severely handicapped as to require education in special schools. Anyone familiar with such children will be only too aware of the increasing frustration with which these children meet as they grow older. Unable to hear, the development of speech is inadequate, if present at all. Lacking the means to communicate their physical and emotional needs (sign language is a very poor substitute for spoken language) abnormal behaviour and psychological patterns develop. Educational attainments are necessarily curtailed and, on leaving school, inability to obtain suitable employment at an economic level or

anything approaching a normal happy social life amongst all classes of a mixed society merely adds to their frustration. Finally, in the narrow society in which their disability forces them to live, inter-marriage amongst those with familial and hereditary deafness often results in children with similar disabilities.

“ Research workers and pioneers in this field have shown that almost every severely deaf child has some ‘islets of residual hearing’ which, if stimulated early enough, persistently and adequately for a sufficiently prolonged period, can result in a varied degree of comprehensive hearing and subsequent speech. They have achieved such success as to allow of such children being educated in normal schools by the time school age has been reached.

“ To accomplish such results, every child must have its reactions to sound tested in the first few weeks or months of life and, where these are deficient, deafness must be suspected and the child kept under observation and investigated until deafness has been detected or disproved. In Cumberland every child ‘At Risk’ is so investigated by a team of specially trained health visitors. In many cases it may prove impossible to detect deafness with any certainty, let alone assess the degree of deafness at such an early age, but if at nine months suspicion of deafness still exists, a hearing aid is provided and the mother instructed in how to accustom her child to its use and given constant advice about her possibly deaf child and the best way in which to stimulate development of both hearing and speech. By the age of two or three deafness should be apparent and, at this stage, the teacher of the deaf should institute ‘intensive auditory training’ directed towards the early education of the child. By the age of five many really deaf children, adequately managed, should be educable in at least a special class for deaf children attached to one of the normal schools in one or two main centres in the County.

“ A suitably sound-proofed room has been provided in which more accurate clinical tests of hearing can be carried out. Facilities are also to be provided whereby joint consultation between all those engaged in the management of deaf children will be more readily available.

“ One apparent deficiency in present arrangements is in the degree of ‘intensive auditory training’ that is available at present. The teachers of the deaf in whose hands lie the future education of these deaf children are in very short supply. They are only able to give some two or three hourly sessions of instruction to mothers and children per week because of the impossibility of frequent attendance at their clinics or more frequent visits to the child’s home on account of distances to be covered. More teachers of the deaf are required or, alternatively, the provision of a small hostel for perhaps four mothers and deaf babes, for periods of up to three weeks at a time every three or four months. During this time the children could receive intensive training for three to four hours daily and routine assessments made by paediatricians, psychologists, otologists or other specialists as necessary. Intensive lip reading and, if necessary, speech therapy, could also be provided in this way. In the new West Cumberland Hospital, mother-baby units are available and it is hoped that they may be used in this way when the necessity arises. Perhaps the planning authorities for the future development scheme for the Cumberland Infirmary already have this need in mind!

“ The special class attached to a normal school, already mentioned above, may well be required in the near future and, where the families with deaf children reside too far from such schools, it should not prove beyond the powers of the Welfare State to provide accommodation and even employment for the whole family so as to facilitate the deaf child’s education.”

Audiology Services

The appointment during the year of a second peripatetic teacher of the deaf has made possible much more comprehensive follow up of children detected as having a significant hearing loss.

With the introduction of area administration during 1964, slight variations arise in the methods applied to audiology work, as indeed to most other aspects of the work, each reflecting the area medical officer’s own approach to the subject.

The account given here of the audiology services links obviously and closely with Mr. Page’s comments on page 34 in connection with the ear, nose and throat surgeons’ specialist services.

Dr. J. L. Hunter, who has most experience of this work in the County, has contributed introductory notes on the service. Thereafter I show similar data for each of the three areas with regard to the number of school children in the main entrant group tested in the year and the results which this produced (Table I): similarly, for those referred as "specials" out-with the main entrant group (Table II). Next is shown disposal of cases detected on first screening as possibly deaf to some degree (Table III). Then the area medical officers submit comments on the pattern of screening and follow-up and on some cases in their areas.

Dr. Hunter writes as follows:—

"The terms 'detection of deafness' and 'ascertainment of deafness' have been used in reporting on this sphere of work since the two foundations of simple testing of infants and the screening of school entrants were laid down in this County six years ago. These two screening systems, assiduously applied, have brought to notice at an earlier date for investigation cases of significant deafness or impaired hearing and conditions of the ear, nose and throat requiring treatment or the renewal of treatment. There is now greater awareness on the part of parents, teachers and family doctors that there is ready help in solving hearing difficulties in children. The application of these techniques and the follow-up by school medical officer, otologist and teacher of the deaf have gone a long way on the preventive aspect by the promotion of interest in clearing up septic conditions of the ear.

"In terms of sensory loss it is in most cases not too difficult to define that loss and fit the child into a category or regime of training or treatment within the present range available—from a favourable position in the ordinary classroom to residential treatment in a special school. In terms of communicative loss or social deprivation, however, difficulties and doubts arise. Dr. Edith Whetnall and Dr. D. B. Fry in their book, 'The Deaf Child,' emphasise the rôle of sound in the physiological development of the sense of hearing in the very young and the close relationship of oft-repeated and meaningful sound first between mother and child and later in the home situation and school environment among ordinary hearing people. She also postulates that a deaf child is better catered for socially and educationally in his home environment with parent guidance

and later in school (perhaps best, a boarding school that is suitably aware of the needs in deafness among hearing children) rather than in the traditional school for the deaf where he is taught and trained among his deaf peers. Trials of such methods will, no doubt, be undertaken in large centres of population containing well-established audiology centres.

“However, with thoughts of help to the mother with a deaf child and as part of his auditory training and social integration, a play centre for the young deaf child was started during the year at Flatt Walks Clinic, Whitehaven. A weekly session was held in conjunction with the Child Welfare Clinic in a room set up with large and small toys, with space to play circle games. Two or three severely deaf children mixed with six to eight hearing children and the session was conducted and guided by young mothers and voluntary helpers. A precise evaluation in terms of any development or improvement in hearing is not easy, but there is some indication that social behaviour and communication with others improved in the deaf children. The experiment proceeds.

“It will be seen that health visitors, the teacher of the deaf, the medical officer of the child welfare centre, now more effectively carry forward the infant to the school situation in this sphere of deafness. At the other end of school age the significantly deaf child leaving school at fifteen years of age, or at sixteen from a special school, comes to an abrupt change in social relationships. The effect of the change is partly cushioned in two ways, firstly by continued supervision by the teacher of the deaf for two years after leaving school and, secondly, by a conference on suitable employment held by the medical officer, the Youth Employment Officer and the teacher of the deaf. Present thought now reaches towards the provision of training and social welfare to those deprived of hearing by injury or disease after school-leaving age. The total need here is not yet known but it is likely to be big enough to set up classes or clubs to cover social contact, teaching in lip reading and sign language or both, under the general guidance of social workers.”

Northern Area

Considerable progress has been made in the north during the last year. In addition to the routine testing of all school entrants and all older children transferred from outside schools

who have no record of previous testing, teachers have been encouraged to put forward any child whose hearing they consider to be even intermittently and slightly impaired, even if they have had a previously normal test. Also an attempt has been made in the course of the routine school medical inspection to pick up children in the older age groups, i.e., outside the present age range for routine testing, who have any previous history of ear trouble or deafness, no matter how trivial or remote. Whilst coverage of the school population is not yet 100% it is hoped that all children who may be considered "at risk" have now been screened and no child with a moderate hearing loss has now been overlooked.

Of those 2,221 children routinely tested (see Table 1), 240 (10.8%) were found to have defective hearing at the first screening ("apparent loss")—an increase from the 6% found in the same group last year but more in keeping with the proportions detected in other parts of the county. The number of routine entrants shown as being tested in this area is much higher than in the west or the south. This is mainly accounted for by the fact that in the first two full years of routine screening in the northern area an attempt has been made to cover three annual entrant groups instead of two, thus making up in a little way for the absence of the service in earlier years.

Referring to Table III on the disposal of these 240 children suspected at first screening, it will be seen that 230 were observed again later, of whom 184 were subsequently cleared on re-examination leaving sixteen for continuing follow-up, apart from those referred to their family doctor or the E.N.T. surgeon.

Of the special referrals, Table II, it will be seen that a very large number, viz., 470, were found in this group in the northern area. This is much larger than the corresponding "special" group for the other two areas and reflects two factors, I suggest. One is the great enthusiasm with which teachers have co-operated in this area with the new audiology service—it will be seen that they referred 330 children. A very significant fact emerging from the total group of special referrals including these 330, was the high proportion, 24%, who were thought to have defective hearing at first examination. The second factor affecting this area is the absence of screening of school entrant groups in earlier years so that many children

are still being referred from the older school age groups who would have been screened at the age of 5 or 6 had the service applied then.

The absence of numbers referred to school medical officers at clinics following audiometric screening does not correspond to the other areas, largely because in almost all cases the audiometrician managed to visit the school before the school medical inspection and the children were then seen at that visit. This is much more satisfactory in the rural northern area than trying to bring children to any central clinic to be seen by the school medical officer.

Since the appointment of Miss O. Cronie last May, more accurate assessment of hearing loss has been possible in the pre-school age group. Health visitors are bringing forward any children whose hearing they consider doubtful at the routine screening in infancy, and also older children who are slow at talking, etc. Whilst in the majority of cases any significant hearing loss has been excluded, in several follow up is still continuing. One rather perturbing feature of the group is that whilst young children with language difficulties, etc., are being brought forward by health visitors (and parents) not one child up to school leaving age has been referred by a general practitioner in the whole of East Cumberland. It may, of course, be that children are in fact reaching us from this source via the health visitors in the pre-school group, although so far the number of under fives found with a significant hearing loss is considerably below the expected figure.

I insert at this point Miss Cronie's report on the work of the peripatetic teacher of the deaf in the North:—

PRE-SCHOOL CHILDREN

" Since May, 1964, when I commenced work in this part of the County, nineteen pre-school children have been referred for assessment of hearing. Eight were referred by assistant county medical officers, ten by health visitors and district nurses, and one by a heart specialist.

" Six of these were found to be hearing within normal limits, ten are under observation, two have very slight losses and one is partially hearing. This little girl, aged four, has made good progress in linguistic development since she came under my care. Her family have been most receptive to guidance, given at home and in the clinic.

PUPILS IN SPECIAL SCHOOLS

“There are seven children in residential special schools outside the County. One boy, aged three, profoundly deaf and with deaf parents, was admitted to the Northern Counties' School for the Deaf, Newcastle, in September. He has settled well and is beginning to make progress. The remaining six were seen during the summer holidays.

CHILDREN WITH IMPAIRED HEARING IN NORMAL SCHOOLS

“Forty-two school children were referred for hearing assessment and follow-up where necessary. Six were found to have normal hearing and two have unilateral losses which at present do not appear to constitute a handicap. Three girls left school in July; two have proceeded to Further Education and the third has found employment. One boy has transferred to London. The remaining thirty children are under supervision. Of these, twenty-one wear Medresco monaural air conduction hearing aids. Nine children are still under observation but appear to be managing with favourable positions in class. Six new hearing aids were issued during 1964 but one was later withdrawn when the child's hearing had reverted to within normal limits. The other five children have accepted their aids and are coping well with them. There has been excellent co-operation with schools and parents.

“Audiometric assessment has been carried out with all these children, particular attention having been paid to speech tests of hearing. Average loss over the main speech frequencies in the better ear is shown in the following table:—

Up to 30 decibels	...	...	...	12
30 to 40 decibels	...	...	...	6
40 to 50 decibels	...	...	...	5
50 to 60 decibels	...	...	...	6
Over 60 decibels	...	...	...	1
				<hr/>
				30
				<hr/>

“Supervision carried out has included parent guidance at home and in the clinics and school visits. Ten children have regular weekly sessions of remedial teaching in reading, language, arithmetic and general knowledge. All children visited have had advice about favourable listening positions in class; those with hearing aids have also had instruction in use of their

aids with hints on lip-reading. Speech correction has been given where necessary and auditory training has been carried out on all occasions."

Western Area

Dr. Hunter makes the following comments on the work in the Western Area:—

"Of those cases detected and classed in the moderately deaf group, i.e., a loss of between 30 and 50 decibels in the three frequencies, 500, 1,000 and 2,000 c.p.s., two are under observation as cases of high frequency loss, while of the others some improved after necessary investigation and treatment of ears or removal of tonsils and adenoids; while others again remain under general observation.

"Of the severely deaf children, i.e., with a loss of over 50 decibels in the three standard frequencies, one was an interesting case of bilateral loss which was brought forward by the child's mother. The deafness was due to a head injury at the age of two years (i.e., at a time when a certain degree of naturally acquired speech had taken place); the losses were in the frequency range of 2,000 c.p.s. and above and the child is responding well with a hearing aid. A further case in the severely deaf group is being followed up as a possible case of true perceptive loss.

"No special etiological factors emerged in these moderate or severe cases except head injury in the case mentioned above and the association of a defect of speech and educational sub-normality in one case of noted bilateral affection.

"In families with a history of otosclerosis a further annual check was made on all the children. In 1964 five families involving thirteen children were so observed. Although otosclerosis does not often appear in school age it should be interesting to check this in school cases who are readily available for audiometry.

"Of the cases severe enough to require hearing aids and so fitted in 1964, one was diagnosed in that year and five first suspected in 1963. All six were perceptive types of deafness; one due to head injury, one occurring in a brain damaged child, one being a case of familial nerve deafness, and three in which no etiological factors came to light."

Southern Area

Dr. Dobson comments on the importance of making a functional assessment of handicap in children found to have defective hearing and basing all procedures on this. Thus a "mild" deafness, while being recorded as a discovery is, in fact, of little practical significance so long as it is confined to one ear. The really significant cases of deafness requiring special attention after all necessary medical measures have been taken, are those who come under the care of the peripatetic teacher of the deaf.

I now include Mr. Abbott's report on his work in the Western and Southern areas of the County in 1964 to complete the picture of audiology work.

PRE-SCHOOL CHILDREN

"During the year two more pre-school children have come under my care, the first being a girl aged four years who had lost her hearing through an attack of meningococcal meningitis, her loss is severe and progress is somewhat slower than I had initially hoped for. The second child is now $2\frac{1}{2}$ years old and is partially hearing, during the six months that she has been under my care and wearing a hearing aid, progress has been very good.

"During the past year two of the pre-school children have been admitted to the Royal Cross School for the Deaf at Preston, both these children being profoundly deaf. I understand that one of the profoundly deaf children will also be admitted to this school at the beginning of the next Summer term.

"Pre-school training and parent guidance has been carried out at various County clinics and in the homes of the children concerned. With one exception, and that not entirely the fault of the parents concerned, co-operation has been good. In fact, in two of the homes I think it would be difficult to improve on conditions and help given. Naturally, these children have benefited greatly from the help given to them daily by devoted parents. Although perhaps the most arduous and difficult part of the peripatetic teacher's work, I think it is right to say that the results in cases like the two mentioned above are very rewarding.

Pre-school group:

Profoundly deaf	...	...	...	1
Severely deaf	...	...	...	2
Partially hearing	...	...	...	2
				<hr/>
				5
				<hr/>

PUPILS IN SPECIAL SCHOOLS

"The number of children in residential special schools for the deaf and partially hearing from West and South Cumberland is now thirteen.

"Two children were admitted to the Preston School in September and I understand that they have settled down very well. In the last twelve months three children from the area have left residential special schools, one boy from the school at Harewood has gone to a local secondary school where he has integrated quite well despite his handicap, thanks to a great degree being due to the sympathy and understanding of the headmaster concerned. A second boy has started work locally and, after several visits, I feel sure he has a job well suited to his capabilities. The third child is a partially hearing girl who has settled well at work and, with some help from the local Vicar, has managed to find useful social contacts at the church youth club. The girl found that on leaving the residential school she had lost her own friends and was initially finding it difficult to make friends of her own age; the youth club has remedied this to a heartening degree.

"It was arranged to see all of the children during the first part of the annual Summer holiday. Once again I felt that some of the schools concerned were careful to see that pupils came home with satisfactorily functioning hearing aids and properly fitting moulds, whilst others left something to be desired in this direction. Four of the parents have, at my suggestion, provided inductance loop systems connected to the television set for the use of the children when home on holiday.

CHILDREN WITH IMPAIRED HEARING IN NORMAL SCHOOLS

"In West and South Cumberland thirty-six children with impaired hearing are under supervision, one of the children is

in a training centre; one in Dovenby hospital; the rest being in various local schools. Thirty-one of these children have Medresco mon-aural air conduction aids and one girl has a Medresco bone conduction model.

HEARING AIDS

“ Seven children have been provided with aids in the last year, six of them being in primary schools and one, a girl, in a secondary school. The six have accepted the aids quite well, whilst the seventh child, although wearing it without too much bother, currently considered it at least a cosmetic problem at first and even now is rather self-conscious about it. This girl’s hearing problem was discovered somewhat late in life as she was living abroad until 11 years of age. Again we have a number of children who are not currently wearing their aids as their respective losses have dropped to insignificant levels. Recently a boy of 14 years has stopped using his aid after almost ten years of constant use, because his average loss is down to 30 db. in one ear and is virtually normal in the other. Because of the vast improvement in this particular case extensive pure tone and speech audiometry has been undertaken to make absolutely sure that no error had occurred in testing. Routine testing of all the children has been undertaken at approximately six monthly intervals.

“ The following table shows the average hearing loss for speech taken on the main frequencies concerned. This is not, however, a complete picture of a child’s difficulties because of high frequency losses above the 2 kcps. mark, low intelligence etc.

SOUTH AND WEST CUMBERLAND				
Up to 30 db.	...	...	...	21
30 to 40 db. ...	...	...	...	9
40 to 50 db. ...	...	...	...	4
50 to 60 db. ...	...	...	...	1
60 db.+ ...	...	...	...	1
				<hr/> 36 <hr/>

“ During the last year four children have left school and they are all now satisfactorily in employment. Two of the children are now under my colleague in East Cumberland. It is noted that a few of these children have been re-categorised in the table on page 45 because of routine testing.

“ Supervision has been carried out as follows:—

1. Supervision which includes use of the hearing aid, class-room position for hearing and lip reading, testing of hearing loss, speech, etc.
2. Remedial work for language and reading difficulties.
3. More specialised work, such as speech improvement, auditory training and lip reading exercises.”

TABLE I
ENTRANT GROUPS

Area	1959	Year of Birth		Total	No. with apparent loss	No. of re-tests	No. requiring investigation
		1958	1957				
North	987	1107	127	2221	240 (10.8%)	297	87 (3.9%)
West	593	799	186	1578	192 (12.1%)	218	84 (5.3%)
South	450	719	153	1322	188 (13.6%)	245	86 (6.5%)

TABLE II
SPECIAL CASES REFERRED

Referred for testing by:	North	West	South	Totals
School Medical Officer	136	64	57	257
Family Doctor	—	1	3	4
Head Teacher	330	45	15	390
Parent	—	5	3	8
Speech Therapist	4	—	—	4
	470	115	78	663

TABLE III

Disposal of cases Discovered:	Routine		South	North	Special West	South	North	Totals
	West	East						
For observation	47	...	59	106	18	23	336	65 ... 82
Referred to School Officer	25	...	18	—	19	13	—	44 ... 31
Referred to General Practitioner	1	...	1	—	2	3	4	3 ... 4
Referred to Otologist	10	...	8	7	12	9	33	22 ... 17
	83	...	86	113	51	48	373	134 ... 134

Visual Defects

The total number of vision tests carried out on school children by school medical officers or school nurses in 1964 was 19,703.

This total was arrived at following the routine testing of children's vision at four stages in school life, viz., at entrance to school, at eight years of age and at routine medical inspections at the approximate ages of ten and fourteen. This pattern is now modified to some extent, however, by the scheme of selective medical examinations in the southern area, in the course of which an attempt is made to examine and test every child's vision annually.

School entrant examinations accounted for 3,961 (3,230) of the above, 137 (172) being referred for treatment and a further 501 (461) for observation. In the eight year old age group, 2,837 (2,918) children were tested, 94 (167) referred for treatment and 324 (355) for observation. The figures shown in brackets are the corresponding figures for 1963.

During the year several pieces of apparatus have been drawn to my attention, designed to facilitate the screening of school children's vision under constant conditions of light and reading distance. It is often difficult to ensure that children's vision is being tested really accurately from these points of view in all school and clinic situations and that re-examinations are for this reason strictly comparable with earlier results. It is certain that with regard to light conditions the circumstances vary very widely. At the time of writing this report one vision screener of a relatively simple pattern of design and operation is being acquired for experimental use in one area of the county. One of its advantages is that it allows of rapid screening of near vision and colour vision as well as the usual distant vision testing. I am giving some consideration at the present moment as to whether it should be used by a single technician, probably the audiometrician, operating it at the same time as the sweep testing of hearing. I find the possibilities of this sort of apparatus most promising and it should help to make for more uniform colour vision screening than has hitherto been achieved in schools.

Last year three of the consultant ophthalmologists made interesting and helpful contributions to my report. One of the points which was brought out by all three concerned the great

need for further orthoptic treatment of children suffering from squint. I am glad to be able to report that two of the possibilities discussed with my colleagues at that time have been followed up, each with some measure of success.

The first concerned the hope of attracting an orthoptist to an appointment which was a joint one between the hospital authorities and the local authority. Early in 1965 when this report was being written, such an appointment had been made in West Cumberland, which will provide the services of an orthoptist in local authority clinics on two full days per week, in the West Cumberland Hospital for two full days, and at the Cumberland Infirmary, Carlisle, for one day.

The second measure which is beginning to show some promise is the establishment by the education authority of a scholarship scheme for girls to study orthoptics, returning for a period of at least two years to work in Cumberland thereafter. The first girl has been selected for this and although it will be about three years from now before her services are available in the County, this is, I believe, a most important advance in this field which has been so constantly a source of anxiety to myself and to my ophthalmic colleagues.

In the year 1964, however, we have been extremely grateful for the continued services of Mrs. G. M. Richardson on a part-time basis in Carlisle. Three sessions weekly have been spent at the clinic at Portland Square and one at the Cumberland Infirmary. In addition Mrs. Richardson carried out two sessions a month for part of the year in West Cumberland at which many of the most urgent cases received treatment in that area. The appointment by the West Cumberland Hospital Management Committee, in conjunction with the local authority, will now happily take care of the West Cumberland cases.

Orthoptic Services

Mrs. Richardson has kindly written the following short report on her work during 1964 and has also supplied the figures in the following table showing details of the cases treated in the year.

“The work in the orthoptic department has continued steadily throughout 1964 and the backlog of patients awaiting treatment, which accumulated during the period 1962/63, has

almost completely been wiped out. There is, however, still a waiting list for children in need of orthoptic exercises and it is a pity that more time cannot be given at the moment to pre- and post-operative treatment—a very important part of an orthoptist's work—in aiding the ophthalmic surgeon, once the eyes have been put straight by means of surgery, to ascertain that binocular single vision is maintained.

‘Most of the work has been centred at Portland Square. As from June, 1964, one session per week has been carried out at the Cumberland Infirmary, Carlisle. Only a minimum amount of work has been possible in West Cumberland. This has meant a good deal of travelling for some patients, but in spite of this, it is interesting to note that there have been good attendances throughout the year.

“The recent appointment of a second orthoptist in the County is most welcome.”

Details of cases treated during the year are given below:—

Total number of attendances in 1964	...	...	...	...	845
Number of new cases seen	...	...	...	...	191
Number of new cases registered for treatment					155
Number of cases receiving treatment on 31st December, 1964	...	...	...	...	168

Treatment during year of new cases:

Partially accommodative squint	...	...	...	...	36
Partially accommodative squint with amblyopia					13
Fully accommodative squint	...	...	...	...	15
Convergence excess	...	...	...	...	12
Tonic convergent squint	...	...	...	...	23
Tonic convergent squint with amblyopia	...				12
Convergent squint secondary to congenital myopia					1
Esophoria	...	...	...	...	4
Fixation disparity	...	...	...	...	1
Amblyopia	...	...	...	...	4
Constant divergent squint	...	...	...	...	3
Divergence excess	...	...	...	...	13
Convergence weakness	...	...	...	...	3

Consecutive divergence	...	...	...	3
Exophoria	...	...	...	4
Convergence insufficiency	...	...	...	2
Vertical muscle palsy	...	...	...	6
				<hr/>
				155
				<hr/>

Discharges during the year:

Cured	...	...	...	...	...	6
Cosmetic		...	...	...	...	9
Improved	...	...	...	...	...	5
Failed to attend		...	...	...	...	6
Left district	...	...	...	...	...	3
						<hr/>
						29

Orthopaedic and Postural Conditions

During 1964 a slightly higher number of cases was cared for in the clinics conducted by the three consultant orthopaedic surgeons seconded by the Regional Hospital Board and assisted by Miss Morris and Miss Fraser, the County Council orthopaedic physiotherapists.

Number of cases on aftercare register, 1.1.64	...	1,174
New cases during 1964	...	139
Cases referred for orthopaedic physiotherapist only	...	224
Cases re-notified after previous discharge	...	7
Cases attaining school age after having been referred originally from child welfare clinic	...	88
Number removed from register	...	357
Number on register at 31.12.64	...	1,275
Attendances at surgeons' clinics	...	798
Attendances at physiotherapists' clinics	...	2,972
Home visits by orthopaedic physiotherapists	...	429
Plasters applied	...	81
Surgical boots and appliances supplied and renewed (including insoles)...	...	458
X-ray examinations during 1964	...	50

Conditions treated at Orthopaedic Clinics:

Flat feet	...	...	...	...	460
Bow legs and knock knees	...	...	...	...	310
Poliomyelitis	...	...	...	...	34
Scoliosis, lordosis and kyphosis	...	...	...	...	15
Congenital defects (including talipes and pes cavus)	...	...	...	...	132
Congenital dislocation of the hip	...	...	...	...	19
Torticollis	...	...	...	...	7
Injuries (including fractures)	...	...	...	...	5
Cerebral palsy	...	...	...	...	69
Postural defects	...	...	...	...	72
Hallux valgus and deformed toes	...	...	...	...	38
Disc	...	...	...	...	—
Birth injuries (Erbs)	...	...	...	...	7
Osteomyelitis	...	...	...	...	2
Perthe's disease and coxa vara	...	...	...	...	14
Arthritis	...	...	...	...	2
Spina Bifida	...	...	...	...	3
Synovitis and rheumatism	...	...	...	...	—
Schlatter's disease	...	...	...	...	5
Muscular dystrophy	...	...	...	...	2
T.B. joints	...	...	...	...	3
Paraplegia	...	...	...	...	2
Other conditions	...	...	...	...	74
					<hr/> 1,275 <hr/>

Mr. G. C. Gordon, consultant orthopaedic surgeon, makes the following comment on the work in these clinics:—

“With the virtual disappearance of tuberculosis and anterior poliomyelitis, school clinics now show a greater emphasis on minor limb deformities and irregularities of posture or gait. Generally speaking, the early development of children is coming more into prominence and this aspect is emphasised by increase in interest in the etiology of treatment of congenital deformities. The school clinic makes a valuable contribution to the early discovery and treatment of the above-mentioned conditions.”

Towards the end of the year a discussion was held with the school medical officers and the two full-time chiropodists

working in the County. The work of the latter is almost entirely at present associated with elderly people but the need for a chiropody service for school children was under critical discussion. Everyone recognised, of course, the importance of any health educational measures which might influence the children or their parents in the important matter of correct footwear, undoubtedly the most fruitful source of minor and, sometimes, major foot defects in later school and adult life. As a follow up of this discussion, at present in the southern area the chiropodists are carrying out a pilot survey with the school medical officers in groups of school children at their routine medical examinations in an effort to establish the kind of need which might exist for a chiropody service for school children. When this is completed and examined it may be that it would be time well spent for one of the area medical officers and the chiropodist to study at first hand the operation of a school chiropody service in one of the areas where this already functions. I hope to be able to report next year on the outcome of these investigations of this important subject.

Speech Therapy

After a prolonged absence during 1963 we were fortunate in that Miss E. B. Moon was able to resume on a sessional basis towards the end of 1963 and now undertakes regular weekly clinics at Penrith and Keswick. Both Mrs. M. V. Aitchison and Mrs. S. Latimer continued during the year on a part-time basis.

With the increased sessional assistance available during the year, it has been possible to arrange fortnightly clinics at Whitehaven and Workington and, consequently, the lengthy waiting lists in these areas have been substantially reduced. Occasional clinics are held in Millom as circumstances permit.

Mrs. E. M. Blacklock comments as follows on the selective service : —

“ In April it was decided that in spite of the shortage of staff the speech therapy service would have to be extended to cover the southern area where there had then been no speech therapy for over twelve months, so a survey of all patients waiting for treatment in that area was carried out in Whitehaven and Millom. At Whitehaven eighty-three appointments were

sent and fifty-one kept. From these twenty-two were discharged, twenty-six were urgently needing treatment and twenty-one were put on periodic review. In Millom twenty-two appointments were sent and sixteen kept. From these four were discharged, three were priority who accepted regular treatment at Whitehaven and nine were put on review.

“In May a survey was done in the Workington district of the western area. One hundred and seven appointments were sent out: of these fifty-seven were kept and twenty-two needed treatment, while eighteen were put on review. Already nineteen patients from Workington were being treated weekly. It became apparent that the only solution was fortnightly treatment for patients in Wigton, Aspatria, Maryport, Workington and Whitehaven. Elsewhere the clinics have been held weekly.”

Miss Moon has this year contributed the following interesting commentary on her work:—

“The overall pattern of defects treated in speech therapy clinics remains fairly constant over the years. Stammering still accounts for the greatest proportion of the case load.

“To take one clinic as an example: twenty-four of the thirty-nine children on the therapist’s register are stammerers and of these three also have articulation defects.

“Most of these stammerers will have to attend the clinic regularly for several years. In many cases this necessity for prolonged treatment during school life could have been prevented if a speech therapist could have seen the child’s parents within a very short time — ideally once a week of the onset of the stammer. The first signs of stammering usually occur between two years to four years. In the very early stages wise management by the child’s parents, under the guidance and with the continuous support of the therapist, can often result in a quick return to fluent speech. All too often parental anxiety is considerable, and wrong methods of ‘helping’ the child have been applied with bad effect, before the child finally arrives at the clinic.

“With the co-operation of health visitors some children have been brought to the clinic in the early stages of the stammer, and it has been possible to prevent it from becoming established.

"We hope that it may be possible to develop this prophylactic aspect of speech therapy during the coming year.

"The fact that the best remedy is not always within the speech therapist's power is illustrated by the case of the child whose stammer cleared up when problems of unsatisfactory living conditions were solved by the acquisition of a new house. Those responsible for re-housing the family incidentally treated the stammer.

"The remaining fifteen children differ widely in the nature, degree and basic cause of their defect.

"Two children were born with severe cleft palates and, in spite of the best that surgery can do for them, have not the physical equipment to acquire normal speech without help.

"In four other cases faulty articulation and inadequate use of language are directly linked to a new low I.Q.

"Seven of the remaining cases have straightforward minor articulation defects. They simply need help to acquire certain speech sounds. They are not up against any serious defect in any part of their speech mechanisms as is the case with the remaining two children.

"The first child presents a picture of general clumsiness. She has difficulty in performing any task requiring finely co-ordinated movements. This general disability makes normal articulation especially difficult for her. Her speech is dysarthric.

"At five years she was unintelligible because she used only those speech sounds that she could make with comparative ease, substituting them for other sounds which she found more difficult.

"She is intelligent, has a good vocabulary for her age, and has learnt to read quickly, but writing is very difficult for her. Her speech is now intelligible but clear articulation requires constant effort on her part. She is denied easy automatic speech by her general disability.

"The second child has no general disability and is also intelligent, but at five years her speech is unintelligible.

"She gives an impression of hearing loss by intently watching the speaker's mouth but an audiometric test showed that her hearing was normal. She can make the fine rapid

movements required for normal speech and will repeat speech sounds correctly as isolated units. She has no dysarthria, but when she tries to reproduce the sequences of speech sounds which make up spoken language some link in the chain of neurological events necessary for normal speech breaks down, and the result is unintelligible. She has an articulatory dyspraxia.

“Whereas the dysarthric child gives a poor performance of the correct sounds, this child gives a good performance of all the wrong sounds. She is up against a real difficulty apparently confined to her speech mechanism.

“Whatever a child’s speech problem may be, co-operation between the therapist and the child’s teacher is of the utmost value, but this is especially true in cases such as the two just described.”

The following table shows details of cases treated and attendances during the year:—

	Northern Area	Western Area	Southern Area	Total
On register 1.1.64	126	113	81	320
Admitted	62	86	64	212
Discharged	64	106	61	231
On register 31.12.64... ..	124	93	84	301
<i>Particulars of cases discharged:—</i>				
Normal	33	47	21	101
Improved, unlikely to benefit further	10	16	4	30
Lack of co-operation ...	10	36	30	76
Left school and/or district ...	11	4	6	21
Passed to teacher of deaf ...	—	2	—	2
Referred to child guidance ...	—	1	—	1
	<hr/> 64	<hr/> 106	<hr/> 61	<hr/> 231
Waiting list	<hr/> —	<hr/> —	<hr/> 14	<hr/> 14
<i>Cases treated:—</i>				
Dyslalia	52	62	32	146
Stammer	61	67	54	182
Stammer and dyslalia ...	11	14	2	27
Sigmatism	1	5	—	6
Cleft palate	12	—	5	17
Hard of hearing	—	2	—	2

Dysarthria	1	2	—	3
Dysphonia	—	—	—	—
Dysphasia	—	—	2	2
Retarded speech development	30	32	42	104
Dyslalia and dysphonia ...	—	—	—	—
Dyslalia plus low intelligence	4	1	—	5
Lateral sigmatism	7	15	1	23
Dyspraxia	6	7	5	18
Submucous cleft	—	—	1	1
Hyponasality	2	—	1	3
Dental deformity	—	1	—	1
Dyslexia and stammer ...	1	—	—	1
Stammer and dyspraxia ...	—	2	—	2
Stammer and dysphonia ...	—	1	—	1
Stammer and dysarthria ...	—	1	—	1
	188	212	145	545

Attendances:—

Northern Area :

Aspatria	70
Carlisle	447
Penrith	525
Wigton	164
Wiggonby School	2
Wigton Infants' School	29

Western Area :

Cockermouth	388
Keswick	107
Maryport	181
Workington	474
Plumbland School	15

Southern Area :

Millom	26
Whitehaven	336

2,764

Child Guidance

The West and South Cumberland child guidance clinics continued during 1964 under Dr. Ferguson's direction and the East Cumberland under Dr. Stuart. It will be seen from the table on page 60 that the number of cases under treatment in West Cumberland has risen. In East Cumberland, although the total numbers in the register are lower than in 1963, the cases remaining under treatment or awaiting treatment have risen.

Writing from the East Cumberland child guidance clinic, Miss Welch, psychiatric social worker, and Dr. H. Blair Hood, educational psychologist, contribute the following comments on their work:—

“The close of the year 1964 saw the East Cumberland clinic supporting a heavier case load than in 1963. In 1964 a total of forty children were receiving or awaiting treatment, compared with twenty-six in the previous year, and we see the possibility of at least some delay in the arrangement of interviews during the early part of 1965. Of all jobs, child guidance must not be carried out under pressure of time. It is seldom that a mother will find it easy to unburden her mind if she feels any sense of urgency during her interview in the clinic, and obviously a fair ration of time is usually needed before a child will reveal himself adequately in his sessions of play or mental testing. The intake of child patients is, therefore, going to need very careful programming during the next few months.

“While the overall picture of child guidance remains the same, there are, perhaps, two trends of which we are all in some degree aware and which we hope will be of permanent significance. One of these is the growing appreciation on the part of doctors, health visitors and others, of the benefits which may follow from the referral of pre-school children for child guidance. The term ‘child guidance’ is, perhaps, a little misleading in such cases, since we are not looking for deeply disturbed emotional states in the young child patient. We are concerned rather with preventing the development of serious emotional conditions by advising parents on the handling of their children and helping them to become more keenly aware of the significance for good or ill of the various social factors

that impinge on their young offspring. It is surprising how often all that is needed is reassurance, to be told that a tantrum-ridden three-year-old may only be going through a normal development stage and not necessarily taking the first step to being a juvenile delinquent.

“The second trend which we think may be emerging is a greater liaison and interchange of ideas between ourselves and others who may share our concern for a particular child. We may, perhaps, express it by saying that the child guidance team does not consist merely of psychiatrist, psychiatric social worker and psychologist, but that according to the need of each child who is seen, other people may become co-opted members of the team; parents obviously, teachers, family and school doctors, health visitors, perhaps speech therapist or teacher of the deaf, occasionally a probation officer or the children's officer and so on. They become members of the team in so far as they may be asked to play an active part in trying to modify the child's environment on the lines suggested by the three who form the permanent nucleus of the team. We think that this trend is apparent and we hope that it is a good one. It should be, provided that it is kept under reasonable control and does not become an unnecessarily time consuming round of conferences.”

I am glad also to report that prospects for the appointment of a child psychiatrist in this area by the Regional Hospital Board are brightening and a recommendation has just been approved by the Joint Sub-Health and Education Committee, asking the Regional Hospital Board to expedite as much as possible such an appointment. Dr. Drummond stressed the need for this in his report last year and I do hope that in the coming year some definite progress will be made on this.

CHILD GUIDANCE CENTRES—STATISTICAL RETURN FOR THE YEAR ENDED 31.12.64

STAFF:		Carlisle:		Maryport:		Whitehaven:		Millom:		Total
		Dr. Stuart	Dr. H. Blair Hood	Dr. Ferguson	Dr. H. Blair Hood	Dr. Ferguson	Dr. Ferguson	Dr. Ferguson	Mr. K. G. Hare	
Psychiatrist ...	...	...	...	...	...	...	...	...	...
Educational Psychologist ...	...	...	...	...	...	...	...	...	...
Psychiatric Social Worker ...	...	...	...	...	...	...	...	...	...
Cases remaining on register at 1st January, 1964	...	26	...	15	...	310	...	26	...	377
New cases referred during year by:—										
Consultants or General Practitioners ...	...	24	...	7	...	5	...	—	...	36
School Medical Officers...	...	5	...	4	...	39	...	1	...	49
Children's Officers ...	...	—	...	1	...	—	...	—	...	1
Parents ...	...	—	...	—	...	1	...	1	...	2
Schools ...	...	8	...	3	...	22	...	5	...	38
Probation Officers or Courts ...	...	—	...	2	...	3	...	1	...	6
Others ...	...	—	...	—	...	—	...	—	...	—
Cases re-opened during year ...	...	1	...	—	...	3	...	—	...	4
Total cases on register during year ...	...	64	...	32	...	383	...	34	...	513
Cases dealt with and closed ...	...	24	...	22	...	10	...	—	...	56
Cases remaining under treatment on 31.12.64 ...	...	33	...	10	...	373	...	34	...	450
Cases awaiting treatment on 31.12.64 ...	...	7	...	—	...	—	...	—	...	7
Interviews by Psychiatrists ...	...	244	...	97	...	248	...	42	...	631
Interviews by Social Workers ...	...	34	...	21	...	—	...	—	...	55
Interviews by Educational Psychologists ...	...	47	...	117	...	335	...	47	...	546

*No social worker

HANDICAPPED PUPILS

That there is a continuance in the care and management of handicaps from birth to old age has long been obvious, and the rôle of a unified local authority department responsible for Health, School Health and Welfare becomes the more clear and important. Educational and vocational guidance carefully moulded to each individual case and handicap sets the stage for the working life. That a wider range of work and professions for seriously handicapped young people is now necessary is exemplified by the two cases mentioned below of seriously physically handicapped youths, both in ordinary schools, who may well require university places.

A further year's experiment has proved the value for the future of the "At Risk" register and the register of congenital abnormalities to which reference was made last year. This consists both in the earlier detection of certain cases as well as the records of potentially handicapped children, in the now more local setting in the areas. Information and consultations are facilitated at a local level under the general care of the area medical officer. As school life commences and proceeds, those children found "unsuitable for education at school" because of mental handicap are provided by the local health authority with appropriate training and care, and those requiring special school provision are gradually sorted out and suitable placings sought. The fact that special school placings for handicapped children (except the educationally subnormal) must all be made outside the County raises problems of communication inevitably for parents and families, and these also become apparent in planning such a child's future employment or career. Developing handicapped leavers' case conferences are already revealing a certain thinness in some cases, of precise information and guidance on a child's educational attainment and employment potential. There is no lack of goodwill and helpfulness on the part of any school so long as those responsible, including School Health Service, Education Department and Ministry of Labour personnel, give a clear enough indication of the information needed and when. It is already apparent, for example, that many handicapped children need a planned multi-disciplinary approach to their employment future, many months and, in some cases, some years before leaving school. Further education services may have a larger rôle to play than in the past and already a

variety of training establishments of handicapped leavers are being mooted or set up.

The full degree of delegation of School Health Service functions to area medical officers is of particular importance, I believe, with regard to handicapped pupils. That detailed recommendations should come from a senior medical officer in direct frequent contact with the department staff and the school staffs associated with a child is tremendously important. His ready contact with the family doctor and specialist concerned are also a reassuring feature of the arrangement.

Blind and Partially Sighted Pupils

A review has been made during the year of all partially sighted pupils in ordinary schools in the County to ensure that there are none for whom further measures should be taken. In the course of a staff meeting which he attended, Dr. Ross Wear, Consultant Ophthalmologist, made the recommendation that the vocational future of these children should be carefully studied at least two years before their leaving date. This has now been established as general practice in connection with handicapped leaver case conferences.

There are six blind children and three partially sighted attending special residential schools outside Cumberland. There are twenty-eight partially sighted children attending schools in Cumberland.

Two further meetings were held during 1964 of parents of blind children in the County. At one of these the headmistress of a Sunshine Home for young blind children gave a fascinating account of her work, supported by a film produced by the Royal National Institute for the Blind, showing the comprehensive range of boarding schools and adolescent training centres which are available for these children as they grow up. These meetings with parents of blind children are undoubtedly successful and an important feature of the support and guidance of the parents.

Deaf and Partially Hearing Pupils

Twenty children under this heading are accommodated in special residential schools.

Undoubtedly the most important single event in this field during the year was our good fortune in the appointment of Miss Cronie as peripatetic teacher of the deaf in East Cumberland. For the first time a comprehensive pattern of care and guidance is offered in the schools for hearing-impaired children and the parent guidance for pre-school children which Mr. Abbott has contributed so effectively in West Cumberland, is now also available in the East.

Gradually the scheme of case conferences on deaf and partially hearing school leavers is expanding to include school leavers of all handicaps. For this group in particular, however, the continuing care of the peripatetic teacher of the deaf for some time after school leaving and the special services of the Diocesan Association for the Deaf in the case of a few profoundly deaf young people is of great advantage. The social welfare officers of the department are beginning now to take an interest in the special problems of the deaf, including the particularly important school leaver group. It is likely that one social welfare officer in each area will develop a special interest in their knowledge of these cases.

Children suffering from Epilepsy

Three of the forty-nine known epileptic school children in the County are in special residential schools. The additional case to those reported last year as away from home is a boy whose case was described briefly and whose home circumstances in terms of access to drugs was particularly worrying. He is now well settled in a residential school for epileptic children and the long and patient work with the parents who were strongly prejudiced against special school has proved well worth while for the child's sake.

Educationally Subnormal Pupils

The table on page 64 gives a picture of referrals, examinations and recommendations on this group of children in 1964. The figures in brackets alongside the totals indicate the corresponding figures for the previous year. It will be seen that although the total number of examinations carried out was lower than in 1963 the number recommended for special educationally subnormal school was little changed. The waiting list for the special residential schools has dropped, partly because of the

removal of an unusually large number of names following parents refusal to accept a place in the school. I think it is likely that many parents who are unwilling to allow a child to leave home for special education, would be more accepting of this help on a day basis, and it is, therefore, with some satisfaction that I welcome the plans proposed by the Director of Education for the establishment of two units in West Cumberland for educationally subnormal children within primary schools. These would be two-class units at three West Cumberland schools. I regard these plans as a very important step forward in relation to the overall provisions for the educationally subnormal child, as an alternative to a day educationally subnormal school. This should provide a clearly improved service for the younger less able children and allow a continuing assessment before the age of possible entry to residential special school which would be most helpful to the school medical officer and others making a recommendation. The need for some form of assessment centre, especially for the children at the lower end of the educationally subnormal range, and at an early age, has occasioned me some further thought in the year. It may be that this should be pursued in conjunction with the above-mentioned development of primary educationally subnormal units in ordinary schools.

2 H.P. EXAMINATIONS COMPLETED IN 1964 UNDER SECTION 34 or 57

Recommended Special School—E.S.N.	...	33	
Recommended Special Class—E.S.N.	... ..	5	
Reported unsuitable for education at school	...	21	
No special educational treatment required	...	5	
Decision deferred	... ..	11	
		<hr/>	
	Total ...	75	(108)
		<hr/>	
Number of boys on waiting list for Ingwell School	... ..	42	
Number of girls on waiting list for Higham School	... ..	32	
		<hr/>	
	Total ...	74	(112)
		<hr/>	

NEW CASES REFERRED IN 1964

*Placed under supervision for further investigation
of intellectual capacity*

Referred by:—

School Medical Officers	...	...	28
Psychologists and Teachers	...	...	16
Consultants and Hospitals	...	...	10
Health Visitors	...	...	11
Others	...	...	10
Total			75 (182)

Supervision of Educationally Subnormal Leavers

Fifty-one of these children left school during 1964 and in that year a higher proportion than previously were placed under supervision; forty-three in all—nineteen to be followed up by health visitors and twenty-four by social welfare officers. I think the advantages of some follow-up for many of these children is to some extent accounting for the high numbers whom the school medical officers are recommending for supervision, also the widening scope of the work of the social welfare officers is a distinct advantage in this context.

A check at the end of the year on those children placed under supervision revealed that of the nineteen referred to health visitors, nine were in regular employment, four were unemployed at the time, a further four had little prospect of employability, and one had been admitted to an adult training centre, one had left the County. Of the twenty-four placed under social welfare officer supervision, ten were in regular employment at the end of the year; nine were unemployed, two had little prospect of employability, and a further two were considered only suitable for employment under sheltered conditions, one was attending an adult training centre.

I have tabulated on page 66 the figures with regard to educationally subnormal leavers and subsequent history over twelve months where possible since the arrangements were commenced for follow-up through health visitors and mental welfare officers. This indicates that at the end of 1964, of the 108 children placed under supervision since 1962, sixty-one were in employment, twenty-nine were unemployed, thirteen were considered to be unemployable, four were in adult training centres and one had left the area.

SUPERVISION OF EDUCATIONALLY SUB-NORMAL SCHOOL LEAVERS

				1962.	1963.	1964.
Total number of leavers	...	...	...	68	42	51
Placed under supervision of Mental Welfare Officers	...	...	...	8	9	24
How placed at end of one year:						
(a) employed	...	...	...	3 (4)	4 (6)	10
(b) unemployed	...	...	...	3 (1)	1 (2)	9
(c) unemployable	...	...	...	2 (2)	1 (1)	4
(d) at training centre	...	...	...	— (1)	3 (—)	1
Placed under supervision of Health Visitors	...	...	...	32	16	19
How placed at end of one year:						
(a) employed	...	...	...	20 (22)	10 (10)	9
(b) unemployed	...	...	...	9 (7)	6 (6)	4
(c) unemployable	...	...	...	3 (2)	— (—)	4
(d) at training centre	...	...	...	— (1)	— (—)	1
						1 (emigrated)

Figures in brackets denote the situation at the end of 1964, of 1962 and 1963 leavers

Physically Handicapped Pupils

Two severely physically handicapped boys in the County are now presenting a new and challenging problem, namely the possibility of university education being sought in the presence of complete inability to walk in either case. Both lads suffered complete paralysis of lower limbs following accidents, but were able to take up the places they had merited in grammar schools, and with all the help and co-operation which the staff and other pupils afforded them, to progress sufficiently to be probable candidates for university places. The challenge which some cases are presenting to the universities is undoubtedly one which will increase as more children with this type of disability pass through schools. This will mainly result from the numbers of children surviving now with congenital deformities of the spine and spinal cord (mainly spina bifida cases). Though neither of these two cases were of this origin, the problems are similar and investigations are being made at present with university authorities on behalf of these two boys in advance of their seeking places on courses. The complexity of this problem is obvious when it is considered that not only of course will there be limitations on the number of university centres who could accommodate such cases, but also considering the further limitations on the types of course which offer a secure career prospect for individuals so physically handicapped.

While the numbers of ascertained physically handicapped pupils are still fairly substantial in terms of heart and chest conditions (58) the severity of these is much less than was the case years ago and, as indicated above, the major categories of severely physically handicapped pupils of the future will be the cerebral palsy ("spastic") group and the other group mentioned above, viz., spina bifida cases. The table on page 68 once again shows the number of children of school age suffering from cerebral palsy. The proportion actually attending ordinary schools or receiving home tuition is forty-seven; those attending special schools for handicapped pupils is nine, while the remaining thirteen attend training centres, are in hospitals for the subnormal, or at home and unable to attend school.

I mentioned in last year's report the opening at Newcastle of a residential unit at the Percy Hedley Centre for young people beyond school age linked to a sheltered workshop. This

opened during 1964 and four Cumberland young people with cerebral palsy were admitted following their attendance at the special school. This further extension of the always invaluable help from this centre and from Dr. Ellis, its Director, has been most welcome.

Children suffering from Cerebral Palsy

The numbers in this category at 31st December, 1964, are as follows:—

Number of spastic children of school age—

North Cumberland	24
South Cumberland	22
West Cumberland	23
Total ...	69

These may be divided into those:—

(a) Attending ordinary school	43
(b) Attending Percy Hedley School for Spastics, Newcastle	5
(c) At Residential Schools for the Physically Handicapped	3
(d) At Residential Schools for the Educationally Subnormal	1
(e) Attending Training Centre	1
(f) At Dovenby Hospital	5
(g) At Prudhoe Hospital	1
(h) Having home tuition	4
(i) Not attending school, not having home tuition	6

In addition:—

Number of children under school age but within the scope of the Education Act, 1944 (i.e., 2-5 years) who are known spastics—

North Cumberland	1
South Cumberland	9
West Cumberland	8
Total ...	18

Table Showing Handicapped Children in Special Schools

BLIND				Boys	Girls
Royal Victoria School for the Blind, Newcastle ...				4	1
Chorleywood College for the Blind, Hertfordshire				—	1
Total ...				4	2
PARTIALLY SIGHTED					
Exhall Grange School, Warwickshire ...	...	...	...	—	1
Preston School for Partially Sighted ...	...	...	...	1	1
Total ...				1	2
DEAF					
Northern Counties School for the Deaf, Newcastle				3	1
St. John's, Boston Spa ...	...	...	...	—	2
Royal Cross School for the Deaf, Preston ...	...	...	...	1	3
Royal Residential Schools for the Deaf, Manchester ...	...	...	...	—	2
Total ...				4	8
PARTIALLY HEARING					
Liverpool School for the Partially Deaf, Southport				1	3
Northern Counties School for the Deaf, Newcastle				1	—
St. John's, Boston Spa ...	...	...	...	—	1
Royal Cross School for the Deaf, Preston ...	...	...	...	—	2
Total ...				2	6
EDUCATIONALLY SUBNORMAL					
Ingwell School, Moor Row ...	...	...	...	48	—
Higham School, Bassenthwaite Lake ...	...	...	...	—	35
York Day School, Carlisle... ...	...	...	...	1	—
Eden Grove School, Bolton, Appleby ...	...	...	...	1	—
Total ...				50	35

EPILEPTIC

	Boys	Girls
Colthurst House School for Epileptics, Warford, Cheshire	2	—
Maghull Home for Epileptics, Liverpool	1	—
Total ...	3	—

DELICATE

Children's Convalescent Home, Cheshire... ..	—	1
Total ...	—	1

PHYSICALLY HANDICAPPED

Hesley Hall School for Physically Handicapped, Tickhill, Notts.	1	—
Percy Hedley School for Spastic Children, Newcastle	2	3
Irton Hall School, Holmrook	2	2
Singleton Hall School, Nr. Blackpool	1	—
Total ...	6	5

DENTAL SERVICE

Mr. R. B. Neal, Principal School Dental Officer, has kindly prepared the following report on the work of the School Dental Service during the year:—

“ It is indeed a pleasure to write a report on the dental services in Cumberland this year because of the great progress which has been made in improving clinic facilities and services. One new clinic, purpose built, was opened at Salterbeck, Workington, and two of the older clinics have been completely modernised and re-equipped—one at Cockermouth and one at Park Lane, Workington. All of these clinics have been supplied with McMaster ‘ Slave ’ units, which are remote controlled and a great asset to both dental officer and surgery assistant alike. Instead of moveable furniture, desks, tables, trolleys, etc., these, together with sinks and wash-hand basins, have been incorporated in built-in formica topped fitments, which make for greater cleanliness and also are more convenient.

“ One must really thank the head teachers of the schools for their great help in assisting with appointments and seeing that they are kept, and also for the keenness of many towards dental health education. At this stage it would be appropriate to mention that the County dental officers are only too pleased to give talks in schools and several pre-nursing classes in secondary modern schools have availed themselves of this service. Only in a very few schools does co-operation leave anything to be desired.

“ The perfect liaison between all the hospital staff and the County dental staff is really worthy of special note and we know that any of us may freely call upon the services of consultant anaesthetists, orthodontists, oral surgeons or specialists in any sphere. The hospitals are most helpful and have even agreed to dental officers working restricted sessions in the orthodontic department, both at the City General Hospital and at the West Cumberland Hospital. This is a step in the right direction because the public health service and the hospital service are so closely related.

“ In January, 1965, a new system of booking appointments and recording work will be introduced in all clinics — this is on the instructions of the Department of Education and

Science — so that all the work done by the local authority dental officers will be recorded in precisely the same way as it is done in private practice and will thus enable the Ministries to assess more readily on a comparative basis the different operative procedures carried out on the varying age groups. The standard forms have been prepared by the Ministry and, once one becomes fully acquainted with them, should lead to better treatment, planning and more efficient records.

“ Millom clinic has been provided with an X-Ray apparatus and this will prove to be of inestimable value because of the clinic's geographical position. In the past a portable machine has had to be taken down as required but, unfortunately, travelling does not do such delicate equipment any good.

“ The County dental officers are encouraged to go on suitable educational and post-graduate courses, so that everyone has the opportunity of keeping up to date with modern methods. Changes are constantly taking place both as regards equipment and drugs, and it is only by attending courses that staff in such an area, which is far remote from any teaching hospital or centre, can hope to keep abreast of the new trends in dental treatment.

“ One cannot emphasise too strongly the advantage of having dental surgeries actually in the schools, although their use for any other purpose is severely limited. The saving in time for both patient and operator is very great and the children seem far happier when treatment is provided on their own familiar ground, but dental treatment in the school is really only a practical proposition in schools of 400 pupils or more.

“ Resignations from dental officers have tended rather to upset what was a very efficient service and, at the present time, there are three vacancies. Mr. J. G. Potter left to take up an appointment with the Department of Education and Science, Mr. D. H. Hayes left to join the Royal Army Dental Corps, and his wife naturally joined him and will work for the local authority nearest to where Mr. Hayes is posted. The good wishes of all the department are extended to all these dental officers. In January Mr. A. B. Gibson will be joining the staff and he will be a great asset because he has been Principal Dental Officer in South Shields for many years.

“During the past year it has been most encouraging to see that, for the first time, the number of fillings done has exceeded the number of teeth extracted, which does definitely show that the school dental service is really functioning very efficiently and that patients are now learning the value of conservative treatment; also that the County staff is now able to tackle the problem in the most satisfactory way.

“What has been said above in no way detracts from comments in early years on the great importance of the fluoridation of water supplies in the substantial reduction of dental caries in children’s teeth. At the time of writing this report there are some encouraging indications that the time may be near when, at least in one area of this County, a scheme could be put in hand for the fluoridation of water supplies. I sincerely hope that next year’s report will be able to show a break-through in this matter.”

I am grateful to Mr. G. H. Roberts, Consultant Orthodontist, for the following note:—

“There is an excellent liaison between the school dental service and the hospital orthodontic service. Patients are sent to the hospital clinics in Carlisle, Workington and Hensingham for advice or specialist treatment of the more difficult cases.

“It has been agreed that at the request of the school dental surgeons the hospital dental laboratory makes orthodontic appliances for school children in need. Moreover, it has been further agreed that individual school dental officers should attend the hospital orthodontic clinics one session per week on a six months’ rota basis. In this way they will be able to gain experience in the selection and treatment of orthodontic patients.

“Because the Hospital Dental Department now has a whole-time orthodontist as well as an oral surgeon and because of the excellent relations between the two services, an effective liaison has been established which should soon lead to a better distribution of orthodontic treatment to Cumberland children as a whole.”

Mr. A. M. Scott, Dental Officer in the Penrith area, has contributed the following report:—

“ Since relinquishing the Brampton area to allow greater concentration on Penrith and district, all the backlog of urgent work has been cleared and an emergency toothache is now a comparatively rare event. The consequences of this are threefold:—

1. Permanent teeth can now be treated in the earliest stages of decay.
2. A proportion of those pupils who are particularly caries-prone can be offered an additional check-up at the clinic a few months after the annual school inspection. (A bi-annual school dental inspection of Group A children would save the operator a lot of time and parents a lot of travelling).
3. A more specialised dentistry can be offered—root fillings, crowns, etc. There has been a definite response to this, most marked in orthodontics, where, at the time of writing, four times as many regulation cases are under active treatment compared with one year ago.

“ In fact the Penrith area is reasonably ‘ tooth conscious,’ due in no small measure to the high standards of colleagues in general dental practice in the town.

“ More specialised dentistry demands more elaborate equipment and it is most encouraging to learn, therefore, that the surgery will be modernised this year. An X-Ray machine on the premises has become essential. A portable kept in Carlisle has not been the answer.

“ This trend, of course, is more exacting and time consuming and does not result in the large numbers of extractions and fillings so beloved of statisticians each December. It does result in a new outlook on the part of the operator to feel that the accent is now on preventive dentistry, but he can only really begin to be effective from school age onwards. How much longer must he wait for the fluoride question to be resolved to take care of those vital pre-school years?”

The highly important work of the two dental technicians is carried out entirely in the background and I am particularly

glad to include the following account by Mr. H. Huddart and Mr. K. E. Green on their work in the year.

“ The work we do is very interesting and varied, far more so than one generally finds in private practice, mainly due to the fact that our work is concerned to a great extent with children. To a large degree our time is taken up by making orthodontic appliances and we cannot adequately express the amount of personal satisfaction which is derived by comparing the plaster casts of patients’ mouths before and after treatment. Despite the fact that I have been a dental technician to the County for twenty-nine years, I am still amazed at the way in which teeth can be moved by small pieces of bent stainless steel wire, with consequent improvement in appearance and articulation.

“ Denture work has made very great progress during the past twenty years, and our main object now is to provide patients with natural appearing restorations which are truly functional as opposed to ‘ artificial teeth ’ of the old days, which were, in many cases, hideously obvious. It is now easily possible to reproduce hypoplastic spots and fillings in anterior teeth by the use of stainers, which makes it very hard to tell which is the natural and which is the artificial tooth.

“ Year by year the number of gold inlays increases and far more crowns, both post and jacket, are being done. There is plenty of scope for artistic ability and manual dexterity, and it is most gratifying to realise how much our services mean to the patients for whom we work.”

PREVENTION OF INFECTION

Protection against Tuberculosis

It is now ten years since B.C.G. vaccination was first offered to school children in Cumberland. In this period a considerable change has occurred in the pattern of tuberculous illness in the area, as well as in the country as a whole. This has been quite clearly reflected in the percentage of positive reactors amongst thirteen year old school children. This has dropped steadily as shown in the graph on page 77. The table shown below again gives the data concerning the cases tested and vaccinated in 1964. This includes a double year group which was included to reduce the age by one year in the first place for B.C.G. vaccination.

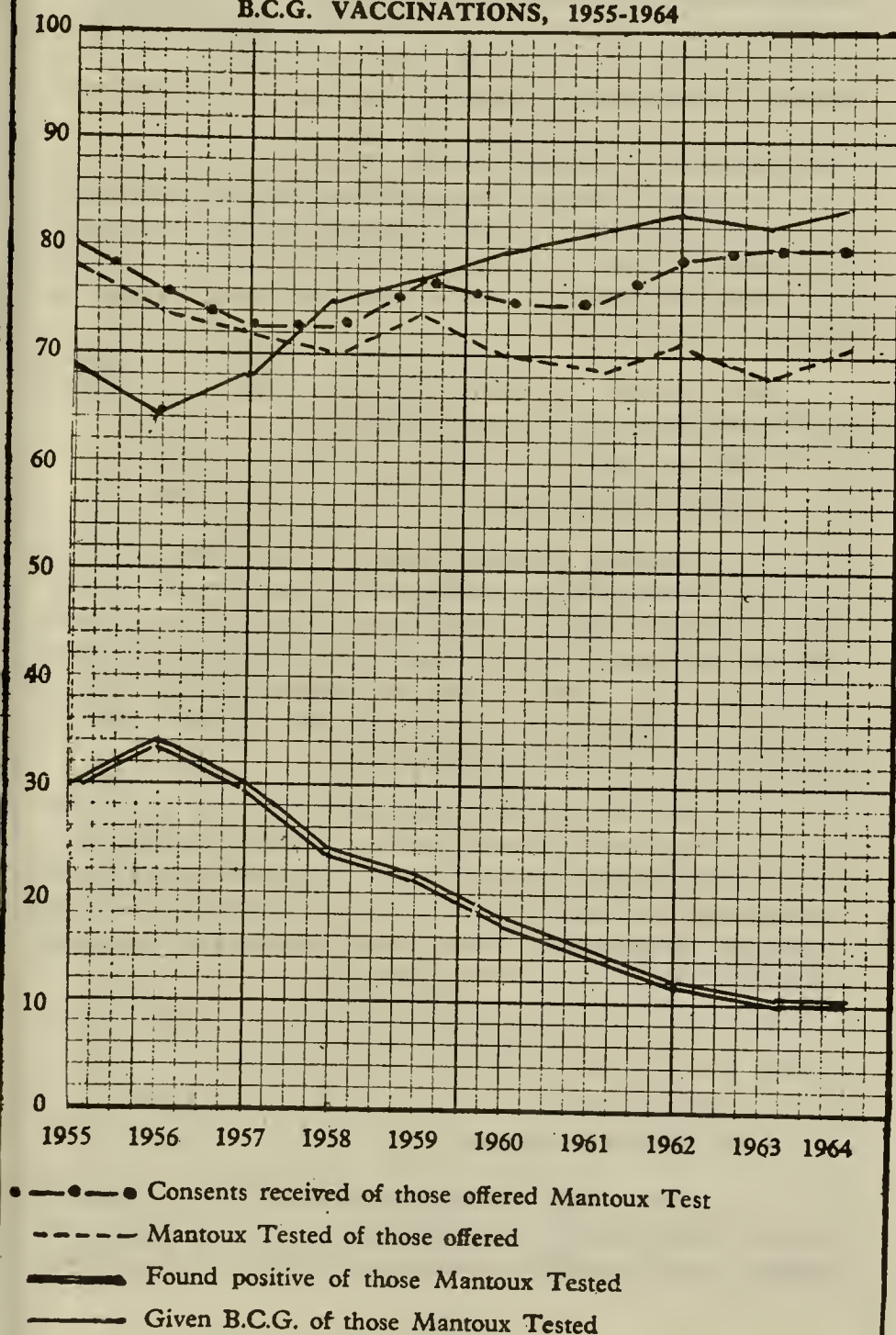
Year	No. offered Mantoux Test	No. of consents	% of consents	No. Mantoux tested	% tested of those offered	No. found positive	% found positive	No. given B.C.G.
1964	6,676	5,332	80	4,733	71	526	11.1	3,965
1963	3,614	2,904	80	2,465	68	294	11.9	2,023
1962	3,766	2,968	79	2,665	71	356	13.3	2,206

The latest national figure available with regard to percentage positives in school children was a figure of 16% for the year 1962; thus the percentage found positive in Cumberland (13.3) was, at that stage, lower than the national average. In 1962 83% of those Mantoux tested were given B.C.G. vaccination—the corresponding national figure quoted by the Ministry of Education and Science was 72%. I would feel much happier, however, if a higher proportion of parents returned the consent forms for Mantoux testing and B.C.G. vaccination if necessary.

The use of disposable syringes for Mantoux testing and B.C.G. vaccination (except where the Mantoux testing is being carried out by means of the multiple puncture plate technique) has proved of great advantage, both in terms of convenience and, more importantly, in the certainty of complete asepsis.

The 526 children giving a positive response to Mantoux skin testing were referred to the chest clinic for large film X-ray. Two hundred and forty-two attended, of whom only one was not satisfactory (non-tuberculous disease). Sixty-three of the 242 were already known by the chest clinic and were under observation. In addition to the above there were 229 children already known to have had B.C.G. vaccination previously.

PERCENTAGES — MANTOUX TESTING AND B.C.G. VACCINATIONS, 1955-1964



In addition to the B.C.G. vaccination scheme described above, routine tours of the mass radiography unit took in schools in the County up to the end of June, 1964. A total of 871 children were X-rayed on these visits. Six were called back to the chest clinic for further investigation, of whom one was found to have inactive tuberculosis and another bronchiectasis.

Protection against Diphtheria and Tetanus

The principal work of immunisation against diphtheria and tetanus in schools has continued during 1964 in the field of reinforcement of earlier primary protection. Reinforcement of this protection is offered at school entry and again between the ages of 9 and 10.

The numbers of school children immunised against *diphtheria* during 1964 were as follows:—

Primary course	...	...	...	1,126
Reinforcing injections	...	...	...	4,661

This represents a further improvement in the immunity index of school children, raising this figure for the school population from fifty-two to sixty-one. It will be appreciated that the aim should be to give approximately 7,500 injections in the course of a year, i.e., two year groups of school children—the entrant group and the 9-10 year olds. In fact it will be seen that some 5,787 were given in 1964.

I can never be satisfied about the protection of the school population against diphtheria until every child is being reinforced twice during school life. Each year occasions a much needed reminder to parents of the vital importance of giving the fullest co-operation to this effort to ensure the continuing absence of diphtheria from the County.

The numbers of school children vaccinated against *tetanus* during 1964 were as follows:—

Primary course	...	...	...	3,500
Reinforcing injections	...	...	...	4,009

The much larger number of school children protected against tetanus in 1964 is accounted for by the substantial number of older pupils in secondary schools in West Cumber-

land who were protected against tetanus alone at the special request of head teachers or parents. Increasingly, of course, children will be coming up through the school years fully protected and reinforced at the appropriate intervals.

The figures shown above indicate that the bulk of children are being kept up to date with regard to tetanus as well as diphtheria immunisation, and the drive now must be towards a complete protection of the whole school population against both tetanus and diphtheria. Apart from the margins which will always be missed through, e.g., illness in each year's "sweep" of the schools, it should be possible to achieve this now that the poliomyelitis vaccination scheme has also settled down to a fixed routine procedure.

Indeed, the next modification of the immunisation programme in schools should be towards still greater simplification. This will probably be the approval by the Ministry of the giving of diphtheria and tetanus reinforcement at school entry at the same time as the fourth dose of oral poliomyelitis vaccine. It is understood that trials are in progress on this and it would certainly be an important help in the schools programme if it were found that this joint procedure was possible without disadvantage.

One difficulty which has always confronted the school medical officers in giving reinforcing injections in school is the doubtful accuracy of what information is available in some cases as to the immunisation procedures some children have received previously. Where there is doubt about this in even a few children in a school it may mean an additional visit of the school medical officer in order to cover these children completely by the full course of injections. One area medical officer has just examined a series of small country schools in this respect — ninety-eight children in the twenty-five schools concerned appeared from the records or the absence of these, to require primary diphtheria immunisation, while 150 appeared to require reinforcement injections. At this stage the form of consent was sent to the parents asking for what information they could give about the child's previous inoculations. If this indicated that nothing had been given in infancy it was assumed that the child should receive primary immunisation. Where the

parent indicated that immunisations had been given by another authority or by a general practitioner this was checked with the authority or the general practitioner concerned. This involved enquiries to general practitioners or other authorities in the case of thirty-nine children—twenty-three of these were clearly resolved, leaving sixteen still in doubt with regard to the exact procedures to be adopted at school.

A further series is being undertaken in which those cases where parental comment indicates that nothing has been given will also be followed up to the general practitioner to determine whether a significant proportion of these have in fact been immunised in infancy and parental recollection has failed to produce any helpful information.

Protection against Poliomyelitis

Each child on entry to school was offered a fourth reinforcing dose of oral poliomyelitis vaccine or, in some cases, a primary course where this was necessary. The number receiving reinforcing doses during 1964 was 1,592, while 422 primary courses were given. The figure of 1,592 is somewhat disappointing. Much nearer to a full year group should be covered and I have arranged that those missed in 1964 will be taken in with the 1965 entrants. One of the difficulties relates to the points made above concerning the need for separate visits to schools to give the reinforcing poliomyelitis dose. The virtual absence of poliomyelitis from this country now can only reasonably be attributed to the vigorous campaign waged over the past few years, and a continuance of this happy state of affairs, as with the other preventable infectious diseases, depends entirely upon the maintenance of a high level immunity, especially amongst children.

Infectious Diseases

The incidence of notified infectious disease in school children is shown in the table on page 82. The number of measles notifications remained substantial during the year. The Spring of 1965 may well see the peak of an epidemic period for measles. This could be a historic landmark in the history of this disease because it is likely within a very short time the degree of protection afforded by the measles vaccines at present

under study will be known and also the most advantageous procedure for protecting children against this disease. There are many facets of this subject, including the balance between the severity of measles when it does occur nowadays, and the possible reactions to any vaccine administered. By the time next year's annual report on the School Health Service comes to be written, it may well be that the position on this subject will be cleared up.

A welcome reduction appears this year in the total notifications of dysentery and food poisoning together — six as compared with twenty-six in 1963. Too much cannot be deduced from small figures like this, but it is to be hoped that the measures mentioned last year providing guidance to school meals kitchen staff and which have proceeded during 1964, will contribute to a continuing improvement in this type of infection. No outbreaks of gastro-intestinal infection were reported from any schools during the year.

One condition which is not notifiable has, however, re-appeared in a small way amongst school children in the year and this has been reported from other parts of the country at present. This is scabies which has not been seen in school children for a number of years. This is only occurring in small numbers of children and when attacked vigorously by parents and School Health Service staff in co-operation can be securely eliminated. In some poorer homes, however, careful follow-up is required to safeguard against reinfection from adult members of the family whose infection may be incompletely eliminated.

Cases of Infectious Diseases in Children of School Age, 1964

	Scarlet Fever	Whooping Cough	Measles (excluding Rubella)	Dysentery	Meningococcal Infection	Ac. Pneumonia	Food Poisoning	T.B. Respiratory	T.B. Meninges & C.N.S.	T.B. Other	TOTAL
URBAN:											
Cockermouth	1	1	1	1	—	—	—	—	—	—	4
Keswick	—	—	27	—	—	—	—	—	—	—	27
Maryport	5	—	1	—	—	—	—	—	—	—	6
Penrith	4	—	71	—	—	—	—	—	—	—	75
Whitehaven...	38	3	34	—	—	—	—	—	—	—	75
Workington...	3	8	146	3	—	—	—	—	—	1	161
RURAL:											
Alston	—	—	2	—	—	—	—	—	—	—	2
Border	—	3	33	—	—	—	—	—	—	—	36
Cockermouth	19	11	69	1	—	—	—	—	—	—	100
Ennerdale	2	2	44	1	—	—	—	2	—	—	51
Millom	—	3	25	—	—	1	—	1	—	—	30
Penrith	1	1	53	—	—	—	—	—	—	—	55
Wigton	6	13	—	—	—	—	—	2	—	—	21
	79	45	506	6	—	1	—	5	—	1	643

No notifications were received in respect of poliomyelitis, diphtheria and smallpox.

Swimming Baths

Towards the end of the year a swimming bath was installed at Wyndham School, Egremont. This serves several schools in the Egremont area, is used by various clubs and for further education activities, and is also available to the public at certain times each week.

The filtration plant is of the continuous pressure sand and gravel type with mechanical gas chlorination. Arrangements are in hand for regular follow-up by water sampling.

A further swimming pool is in course of construction at Keswick Grammar School through the efforts of the parents/teachers organisation and is expected to be completed towards the latter part of 1965.

In my report last year I mentioned the difficulties in obtaining consistently satisfactory bacteriological samples of water from the permanent pool at Solway School, Maryport, and it was agreed to install a larger filtration plant which was expected to remedy the anomalies in testing and unsatisfactory water samples. A larger chlorination plant and filters were installed during the Summer of 1964 and, since the re-opening of the baths in October, samples of water have been taken on nine occasions, two of which proved to be unsatisfactory.

Dr. Campbell, Maryport Urban District, reports that on the whole the present system is working satisfactorily, but the situation will be carefully followed up. Latterly the samples of water have been taken towards the end of the week when the load is greater, by special arrangement with Dr. Davies, who kindly consented to receive samples at the Public Health Laboratory on Thursdays.

The following comments on the swimming pools at Millom Comprehensive School and Seascale Primary School have been provided by Dr. Crowley, Millom Rural District:—

“The swimming pool at Millom Comprehensive School offers facilities for swimming to all those wishing to take advantage of them. At the beginning of the Summer term the pool is filled through the good offices of the Fire Brigade. The filter and chlorination plant is allowed to work for a few days

before swimming is commenced. The degree of chlorination is estimated at regular intervals and adjustments are made as are found necessary. Samples of water are sent for routine analysis at very regular intervals. A sample taken on the 15th June was shown to be unsatisfactory and swimming was discontinued pending investigation, which showed that the filter had broken down. Unfortunately the faulty part could not be substituted throughout the rest of the term, and so no further bathing took place. The filter is now working well and it is hoped that the pool will be available for swimming before the 1965 Easter term commences.

“Seascale Primary School is equipped with a swimming pool which is available to all pupils. It is fitted with an automatic chlorinator and filter. Regular samples are taken for analysis and these have proved to be consistently satisfactory. In 1964 swimming commenced at the beginning of the Summer term and continued throughout that term.”

Water samples taken from the Purley pool at St. Andrew's School, Penrith, were satisfactory, but sampling from the River Eamont, which is used by Penrith school children, still gives rise to some anxiety with regard to contamination from time to time.

Dr. Thomson reports as follows on the swimming bath at Lazonby which, although essentially meant for the use of school children, is also in use by members of the public:—

“The swimming pool is an open-air one with chlorination and cubicles for undressing attached and water samples so far taken have been quite satisfactory. At the time of writing the swimming pool is out of use but when weather conditions are satisfactory and the pool is again in use, further samples of water will be taken.”

HEALTH EDUCATION

No child's education could be said to be adequate without some time allocated to health education and surely any time given specially to this vital subject is time well spent.

The value of health education starts at birth and the part played by a healthy, happy family background is of paramount importance. It is, indeed, these years that play such a vital part in the life of every citizen all through his life. This age is well known as the first.

The second age is of a "whining schoolboy with his satchel and shining morning face creeping like a snail unwilling to school."

It is this stage that concerns us most for the purpose of this report.

Health education should be ever present in the minds of all, but especially in the minds of teachers, parents, doctors and nurses, all of whom play such an important rôle in the child's school life. It must do far more than provide information: it must influence the way people live and act; the habits they form, the clothes they wear. We are all victims of fashion, and the adolescent years, already difficult to cope with, are becoming more perplexed with the advent of an earlier maturing age and consequent early marriage age.

The "never had it so good" era has its own health hazards—the incorrect use of leisure, over-eating and smoking have never before caused the concern to health they do today at all age levels. Be it the young schoolboy who acquires the habit of smoking, school children frequenting coffee bars, or a disturbingly high illegitimacy rate—such anxieties but sharpen the challenge to health education.

New and welcome additions of equipment to the health education department during 1964 were a Bell and Howell sound projector, tape recorder and the usual supply of posters, leaflets, flannelgraphs and new camera talk filmstrips, all of which have been used to the full since purchase.

Subjects taught in schools during the year included:—

	No. of talks	Attendances
1. Maternal and child welfare	10	181
2. Accident prevention and First aid ...	19	402
3. Adolescence's problems	12	260
4. General health topics	38	835
5. Personal hygiene	11	274
6. Prevention of disease	8	198
Totals ...	<u>98</u>	<u>2150</u>

Talks usually last 20-30 minutes and are illustrated by visual aids or filmstrips. "The children are encouraged to take part by discussion and observation of visual aids—this they seem to enjoy very much" a health visitor reports.

Another health visitor writes:—"For the Duke of Edinburgh Bronze Award at one school sixteen girls showed great interest in personal hygiene, skin care, care of hands and feet, care of the hair and teeth and care of the eyes."

"At three other schools I did a series of four talks beginning with a film on menstruation called 'Women of Tomorrow'; second week—how the foetus grows and why antenatal care is important. The third week covered the first year of a baby's life when it is completely dependent, emphasising the needs and dangers. Fourth week—the baby 1-5 years. The girls show great interest in their series and ask many questions."

Junior first aid has been much in demand. A health visitor gave a course of eight lectures and reports:—"These lectures were for the Duke of Edinburgh's Award and the boys' ages were 14 to 15 years. There were twenty-two boys in the class and the attendance was excellent."

In a semi-rural area a health visitor/school nurse reports:—"The mothers in my area meet in different people's homes once a month for a coffee morning. There are usually five or six mothers grouped together and I find by popping in towards the end of the morning I can quite easily start a little discussion group. The topics vary greatly, but one mother usually has some problem which she likes to discuss such as jealousy, night waking, temper tantrums or nail biting."

One mother reported that her two children refused to go to school and the nurse arranged for these two children to be taken by another mother who had children of her own attending the same school. This worked very satisfactorily and there were no more difficulties.

In an urban area where cleanliness had been a problem for many years the nurse reports:—"In this particular school I found the film on 'Care of the Hair' most useful. After a short talk, followed by the film, I am glad to report that there is now only one child with nits in her hair in the whole school."

Further comments by a school nurse are:—"Health education is also important and we try, when the opportunity arises, to show films and give talks to small groups of children. When giving a talk at one of the junior schools during the typhoid outbreak in Scotland, I was amazed at the questions these children asked, and how well informed they appeared to be."

Yet another school nurse reports:—"The general standards of hygiene have been raised considerably, children come to school with clean hands and faces, and many of the children take care of their teeth, perhaps health talks and school dinners being followed by apples or carrots are making some impression."

Impetigo in school children is becoming rare—perhaps this would be even rarer with the use of disposable towels, and further health education.

In a growing industrial area, the main industries being mining, clothing and textiles, a senior mistress of a girls' school with 460 places reports on the health education programme in her school as follows:—"This has comprised infant welfare, prevention of and caring for infectious and other diseases, discussion on smoking, alcohol, home nursing, first aid and personal grooming. I feel this course is very worthwhile for all girls and, especially, the average pupil who is not staying on at school for an extended course, and who will look forward to marriage in a few years' time. The nurses are experts in their subject and there is no one better to administer these talks which really link up with health visiting and its preventive teaching. I feel that (a) many 'old wives' tales' have been

weeded out; (b) we can actually visit a clinic when anything interesting is in progress, e.g., the bathing of a baby; (c) we can co-operate in difficult cases, keeping an eye on and advising any girl in difficult home circumstances; (d) nurse can speak to children individually on personal hygiene — this has greater effect than 'en masse.' We have always had welcome co-operation from the nurses in the district and the girls do look forward to their visits. The girls are examined on the work done. It is a valuable service."

Unfortunatly another school in a similar area showed less enthusiasm for the help which the nurses can give in health education; there this work was regarded as exclusively the province of the teaching staff. I think experience has shown the "syngenetic" effect of teacher and nurse or doctor in partnership.

The problem of another health visitor in school is the lack of black-out material available in a classroom bounded mainly by glass.

Dr. Campbell comments as follows on aspects of health education:—

"The present trend of young persons marrying and starting families at a very early age after leaving school has made it increasingly essential that more and more emphasis be placed on health and hygiene education in schools.

"It is interesting, therefore, to find an increasing number of these young mothers attending child welfare clinics with knowledge of child care and care of themselves and their homes.

"Especially encouraging is the increase in the number of young mothers who, having had unsatisfactory home backgrounds in their youth, are eager to take advice and give their children the care and attention which they themselves lacked in childhood."

Smoking and Health

At least 1,600 children in Cumberland schools saw one of the films used in this continuing campaign during 1964. The impact is notoriously difficult of assessment and any kind of

accurate evaluation even more so. However, discussions with head teachers of secondary schools in one area of the County and subsequent exhibitions of the various films available, produced some interesting features. In the case of one mixed secondary modern school the headmaster was confident that smoking among the pupils had decreased over the previous two years since he himself had stopped smoking. He felt further propaganda at this stage might be unhelpful and he may well be right in this view. At another secondary modern school for boys the film "This is young Lung" was shown after a very brief introductory talk by the area medical officer. Here an impact was evident and I quote from the headmaster's comments:—

"A random verbal survey of the impact made by the recently shown film is as follows:—The impact of the film was considerable and persists. Some boys have given up smoking and others state that they do not intend to start. It was generally considered that the posters have little effect, possibly because of the large numbers of posters on all subjects on display. Of the boys questioned eight had tried to convince their parents of the dangers of smoking; six parents have cut down their smoking and one has not heeded the appeal."

At the nearby girls' secondary school, "The Smoking Machine" was shown but even the youngest girls obviously found it rather juvenile in approach and tended to confirm the view that this film is more suited to the older junior school child.

The showing of "Smoking and You" to another audience of younger grammar school children was very gratifying in the range of intelligent questions and comments forthcoming afterwards. This was not entirely negated by a slip of the tongue on the part of the well—but not quite well enough—rehearsed young man who was sure the talk and film would make them all wish "to stop smoking"—hastily corrected to "not to start"! The headmaster writes as follows of his own and his staff's impression of the effect on the children:—

"The following are the reactions of the members of the 1st, 2nd and 3rd years at this school to the film, 'Smoking and You,' which they saw last term.

- (1) They all claim that they are convinced of the danger from the film and are determined not to smoke because of the fear of cancer.
- (2) They all remember certain details of the film very clearly and seem to appreciate the danger of acquiring a habit which is not easily broken.
- (3) Their general opinion is that older boys and girls start because they imitate others who are seen smoking.

“I am quite sure that much more is achieved by showing these films to younger children than to the 15+ age group who have a much more sophisticated approach.

“When the class discussions on this topic led on to the commercial aspects of the tobacco industry the view of these boys and girls was that advertisements generally are something of a joke. One second form girl, however, felt that she might well be influenced by those in which an irrelevant emotional appeal is made, e.g., pictures of a pleasant stream in a Summer landscape. The vast majority claimed that they were not even influenced by advertisements for sweets.”

RELATED SERVICES

Medical Examinations of Teachers

Full medical examinations (including chest X-ray) are required for teachers to be appointed in the following categories, and who were not at the time of appointment already holding teaching posts in the County:—

- (a) appointments to posts of head, deputy head, senior master, senior mistress in primary and secondary schools;
- (b) appointments to posts of principal, vice-principal, or heads of departments in colleges of further education.

In addition to the above, all persons entering the teaching profession for the first time and those who have been out of the teaching service for a period of twelve months or more are also subject to medical examination.

For other teaching appointments medical examinations are dispensed with, and candidates are required to complete a questionnaire and submit a certificate of satisfactory chest X-ray. From the information given by the candidate in the questionnaire it is decided whether or not a medical examination is indicated.

The number of medical examinations of teachers carried out during the year was 115, while 114 of the questionnaires referred to above were completed.

One hundred and seventy-two candidates for entry to teacher training colleges were also medically examined.

School Premises

Mr. Gordon S. Bessey, Director of Education, has supplied the following note on developments in school premises:—

“New lavatory and sanitary accommodation at Arlecdon School, Brampton Infant School, Bransty School; new premises for Kirkbampton C.E. School; Hensingham Infant School remodelled and extended; new Primary School, Orgill Infants School; The White House School extended; new Secondary Schools: Lochinvar, Longtown and Wyndham, Egremont. Closed: Matterdale School, Workington Lawrence Junior School,

Sowerby Row C.E. School; Dacre C.E. and Newbiggin C.E. (closed at end of the year)—children transferred to new premises for Stainton C.E. School provided by the Managers from January, 1965; Eskdale High C.E. School.

“The Managers remodelled Calthwaite C.E. and Skirwith C.E. Schools and provided new premises for Stainton C.E. School.

“Work was completed on the Governors’ project for the extension and remodelling of Workington St. Joseph’s R.C. Secondary School.”

Sanitary conditions in general in some of the schools, ill-equipped in this respect, have been further improved during the year and this is a very welcome advance. Health education in personal hygiene is bound to be unavailing without premises which provide the basic requirements for good personal hygiene.

School Meals

Mr. Bessey has also supplied the following report on the School Meals Service, together with the note on Milk in Schools which follows:—

“Once again, during 1964, children in attendance at all the 279 nursery, primary and secondary schools maintained by the authority were afforded the opportunity of taking a hot mid-day meal if they so wished. In fact, a check undertaken on a day in September indicated that 80.6% of those present did so. This overall percentage showed an increase of 4.6% over the corresponding figure for last year and constituted an all-time record. Details of the figures for a day in September, 1964, compared with those for a day in September, 1963, are set out below:—

Year	Primary and Nursery Schools			Secondary Schools			All schools combined		
	Number of children present	Number taking meals	Percentage taking meals	Number of children present	Number taking meals	Percentage taking meals	Number of children present	Number taking meals	Percentage taking meals
1964	20,691	15,903	76.9	14,789	12,701	85.9	35,480	28,604	80.6
1963	20,577	14,691	71.4	14,815	12,203	82.4	35,392	26,894	76.0

“A very considerable amount of new building work, as well as some work of adaptation and improvement to existing

premises, was completed during the year and, in consequence, the number of kitchens (including central kitchens) producing dinners at the end of the Autumn term had risen to 131.

“ Fine new premises for Wyndham School at Egremont were partially occupied at the beginning of the Spring term when pupils from the old school were transferred to it and the first of the five 250 meals kitchens was then taken into use. Previously these pupils had been supplied with meals from Egremont Central Kitchen. The school received its first full intake of pupils in September when three more of the kitchens were opened. It is expected that the sixth form refectory will be equipped in time for the official opening of the school in 1965 and initially will be used to provide only evening refreshments for further education students until the sixth form is established.

“ Other developments in Egremont include the provision of a new infant school, Orgill, the erection of new premises for Bookwell Senior School, to be named Orgill Junior School, and the building of new premises for St. Bridget's R.C. School. Orgill Infant School, including a 150 meals kitchen, opened on 1st September, and Orgill Junior and the new premises for St. Bridget's Infant School, with their ancillary meals accommodation, are likely to be ready for occupation about Easter, 1965.

“ Lochinvar School at Longtown was completed early in the year and opened on 7th April. Included in it is a 350 meals kitchen which, besides supplying dinners to pupils attending Lochinvar School, also meets the need for meals for children attending the junior and infant schools. This is a great improvement on the previous arrangement whereby all the Longtown schools were supplied with meals from a poorly-equipped kitchen in cramped, rented accommodation. The former mixed school also dined in this accommodation in somewhat drab surroundings but the infants took the meal in their own school. With the opening of the kitchen at Lochinvar School, children in attendance there and at the junior and infant schools all dine in their own schools. A scullery has been in existence at the infant school for some time and, during the Summer holidays, a former woodwork store was adapted to provide a scullery for the juniors.

“Two more secondary schools, The White House, Brampton, and St. Begh’s R.C., Whitehaven, were also provided with much improved meals facilities during the year. The kitchens at both schools had been in use for many years and much of the equipment in them was nearing the end of its useful life. Furthermore, at both schools, the number of diners had increased progressively over the years and the staffs had experienced the utmost difficulty in maintaining a daily output of meals considerably in excess of that for which the kitchens were nominally equipped.

“In consequence, when the governors of St. Begh’s School announced their intention to undertake a scheme of improvements, the opportunity was taken to include in it the complete re-modelling of the kitchen and the installation in it of some new equipment so as to bring it as nearly as possible up to the standard of a kitchen of 450 meals capacity. The work extended over almost two full terms and during this period meals for pupils at both the Secondary and Junior Schools were provided from Whitehaven Central Kitchen and eaten in classrooms from desks. When the kitchen re-opened on 15th July, ample testimony to the improved standard of meals was provided by the sudden increase in the number of children taking them.

“Similarly, a new 250 meals kitchen was included in large-scale extensions to the White House School. It was taken into use on 13th July.

“The re-modelling of Hensingham Infant School, which included the provision of a 200 meals kitchen, was completed by the Autumn and occupied on 12th October. The assembly hall is used for dining and, in consequence, the Junior School pupils are now able to take their mid-day meal in the dining room adjoining Whitehaven Central Kitchen, which was formerly used by the infants.

“Extensions and rehabilitation schemes were completed by the managers at two small rural schools, Calthwaite C. of E. and Skirwith C. of E. and, in each case, a forty meals kitchen was provided. That at Calthwaite opened on 13th February, meals being served in school. These arrangements superseded the previous practice whereby meals were sent out from

Penrith Central Kitchen and served in the local Reading Room. The opening of a new kitchen at Skirwith School on 7th April did not entail any change in the service of meals since this kitchen merely replaced one which had been in use since August, 1949, but which had to be demolished as part of the scheme of rehabilitation.

“ Another small rural school to benefit from the provision of improved meals facilities during the year was Kirkbampton C. of E. Previously meals had been sent from Wigton Central Kitchen and eaten in the Women’s Institute Hall, but on 1st September the school re-opened in new premises which include a forty meals kitchen.

“ The end of the year saw the completion of the managers’ scheme for the erection of new premises for Stainton C. of E. School to take children from Stainton C. of E., Dacre C. of E., and Newbiggin C. of E. Schools. These new premises were occupied on 5th January, 1965. Some of the children will have to travel a considerable distance but they will now all have the opportunity of taking a hot mid-day meal served direct from a kitchen on the spot, rather than eating container meals sent out from Penrith Central Kitchen.

“ During the year, adaptations were undertaken at Burghby-Sands, Holme St. Cuthbert and Kells Infant Schools in order to improve meals facilities by providing a kitchen in each case. At Burgh three classrooms were adapted to form a kitchen and assembly hall/dining space and production of meals began on 7th April. A similar adaptation of two classrooms at Kells provided a good kitchen and dining room. At Holme St. Cuthbert an existing scullery was adapted and re-equipped to form a kitchen. The improved facilities at Kells Infant and Holme St. Cuthbert Schools were taken into use on 26th October and 1st September respectively.

“ The service of meals at Greystoke School was rendered a little more convenient by adapting a spare classroom to form a dining room and scullery so that children no longer had to dine in the Village Hall as formerly. The improvement became effective on 26th May.

“ For many years children attending Westward C. of E. School have dined in the adjoining Mission Hall and washing-up has been carried out under great difficulty. However, with

the extension of electricity to the Westward area, the Hall Trustees have agreed that the Education Committee might equip a small room off the main hall as a scullery. This was done and the scullery was taken into use on 7th September.

“ Since dining on desks in classrooms at Kirkandrews-on-Eden School and sending used cutlery and crockery back to Wigton Central Kitchen for washing was proving inconvenient, an approach was made to the Trustees of the local Village Hall for the use of their premises and, suitable terms having been agreed, the main hall and supper room were taken into use on 17th February.

“ Because of the dangerous condition of the St. James’ Junior School building at Whitehaven, it became necessary to transfer the children to Crosthwaite Memorial C. of E. School on 7th January and since then they have shared Crosthwaite School’s dining accommodation. However, new premises for St. James’ Junior School, including kitchen and dining accommodation, are now in course of erection.

“ At the end of last year, a choice of menu was being offered at seven secondary schools. During the year under review, this service was extended to a further eight schools, namely:—

The White House, Brampton.
St. Cuthbert’s R.C. Secondary, Cleator Moor.
Lairthwaite, Keswick.
Lochinvar, Longtown.
Kells Secondary, Whitehaven.
St. Begh’s R.C. Secondary, Whitehaven.
Wigton Secondary.
Secondary Technical, Workington.

“ This development continues to be popular with the children.

Milk in Schools

“ The figures given below show the consumption of milk by day pupils present in the 279 nursery, primary and secondary schools maintained by the Authority on a day in

September, 1964, as compared with a day in the same month in 1963:—

Year	Primary and Nursery Schools			Secondary Schools			All schools combined		
	Number of children present	Number taking milk	Percentage taking milk	Number of children present	Number taking milk	Percentage taking milk	Number of children present	Number taking milk	Percentage taking milk
1964	20,691	19,074	92.2	14,789	8,629	58.3	35,480	27,703	78.1
1963	20,577	18,841	91.6	14,815	8,610	58.1	35,392	27,451	77.6

“It is pleasing to note that the trend towards increased milk drinking in schools is being maintained. Indeed, the overall percentage of children taking milk in schools has advanced by almost 10% during the past four years.

“It is equally gratifying to find that the percentage of pasteurised, as opposed to untreated, milk consumed in schools continues to rise steadily. The percentages of the two types being supplied to day children attending maintained schools in September, 1964, compared with the corresponding figures for 1963, are set out below:—

				1964.	1963.
Pasteurised	...	...	...	87.0%	84.7%
Untreated	...	...	...	13.0%	15.3%

“Ten years ago only 51% of milk being consumed was pasteurised.”

The above information provided by the Director of Education is most encouraging and provides the material conditions in which the nutritional advantages of school meals and milk can be realised more fully by our school children.

Further efforts are being pursued towards the comprehensive provision of pasteurised milk in schools. In this connection Dr. Crowley, Assistant School Medical Officer and Medical Officer of Health for Millom Rural District, makes the following comment:—

“In the Summer term a school child was notified as suffering from brucellosis. Investigation revealed that she consumed milk from two sources, one of these sources was at Irton School. Analysis of the milk from each source did not, however, reveal brucellosis to be present in the herd. Nevertheless, it

was strongly advised that the school milk should be pasteurised and a change-over was made accordingly.

“Brucellosis in herds seems to be becoming more common nowadays. For this reason it seems proper to issue an appeal for all milk consumed at schools to be pasteurised. By and large this measure could be carried out fairly easily. The use of pasteurised milk at schools would save the children from the hazard of contamination with brucella organisms, salmonella, etc.”

For children who take school meals and school milk these provide an important part of each day's food requirements. A school dinner with an energy value of 750-1,000 calories, depending on the age of the children, supplies on average 20 grms. of animal protein and 25-30 grms. of fat. In other words, about one-third of the total calorie and protein requirements of the day.

The percentage of children in school taking school meals has tended to be higher in Cumberland than the national average, and this is much as would be expected in a rural area with many children living relatively long distances from school.

Although under-nutrition has ceased to be a problem in school children, and despite the fact that the financial situation of most families has improved very significantly in recent years, the importance of school meals to the general nutritional situation in school children must have been very important. It is difficult to assess this in any accurate terms because of the other parallel social improvements, but school medical officers in this authority have, from time to time, commented on the apparent value of school meals to children from homes where material and financial improvements have not yet outweighed all of the disadvantages and risks of the remaining degree of ignorance of such matters as food values. A beneficial effect on the appetite of the rather “fussy” child has also been noted on learning to eat with school friends in the school situation.

As well as the absolute value of school meals to the individual child, there is also the highly important matter of the health educative value of meals and milk. There is an important opportunity here for children, especially the older

girls who may in a few years be running their own homes, to learn the pattern of a well balanced meal and its significance for health. Perhaps greater opportunity could be taken of the school meals situation to make this point specifically as well as to look to the day-to-day experience in school meals as itself setting a good example.

Another important sphere of health education which can be exploited helpfully in relation to school meals concerns the condition of teeth. The provision of the helpful piece of apple, for example, at the end of a meal has a cleansing effect on the teeth, and opportunity can also be taken to instruct children in the value of simple rinsing of the mouth after a meal even if brushing of the teeth is not practicable.

The possible disadvantages of school tuck shops in depressing appetite for the main mid-day meal should be carefully considered, as well as other factors when these are under consideration.

Physical Education

In April, Cumberland welcomed Miss E. C. McKelvie when she assumed her duties as Woman Organiser of Physical Education.

There should be made available to the individual the time to recuperate and the means of revitalising body, mind and spirit so that he may play a full part at work, at play, in the family and in the community. Facilities for sport and physical recreation, important aspects of social training, should be geared to meet economically the needs of individual taste as personality unfolds in the process of education through school, youth club and centre of further education.

The recent Joint Circular of the Ministry of Housing and Local Government and of the Department of Education and Science upon Provision of Facilities for Sport, published in August, is welcomed as a positive lead in encouraging co-operation between local authorities to plan and to provide recreational facilities suited to the requirements of the community they are intended to serve. It is pleasing to report that in Cumberland this principle of co-operative planning has been

followed for a number of years and that joint schemes now in existence at Alston, Penrith, Moor Row, Cotehill, Brampton and Egremont are proving the value of joint effort. In addition the increasing number of sports organisations affiliated to Centres of Further Education is indicative of the importance which the community attaches to the planned dual use of physical education facilities at our secondary schools and colleges of further education. The Wyndham School, Egremont, is one example of the Committee's policy: another will be the physical recreation centre at Moorclose School, Workington, which should be ready in the Autumn of 1966.

Through the media of schools voluntary associations teachers are educating boys and girls to make full use of their training at school during their leisure hours. Cumberland children owe much to these members of staff who give generously of their spare time for the good of the County's future citizens and thousands of boys and girls have cause to be thankful for help and guidance freely given.

During the year eighty-seven schools took part in activities organised by the Cumberland Schools' Football Association, including residential coaching courses. The Cumberland Schools' Athletic Association held their annual County championships at Whitehaven when forty-seven Cumberland children were selected for the inter-County championships at Hendon. The Cumberland Schools' Badminton Association has shown an expanding programme in school games and coaching for pupils and teachers. In cricket also expansion continues, particularly at district level, and in the number of coaching courses held for selected boys during holiday periods. The Cumberland and Westmorland Schools' Rugby Union has maintained its high standards.

It has again been a vigorous year for girls' activities. Cumberland Hockey Association organised a most successful senior tournament at Wigton which was won by Workington Grammar School, the first school in Cumberland to be equipped with an all-weather surface pitch.

The Cumberland Schools' Swimming Association held its annual gala at Whitehaven when thirteen boys and girls were selected to represent Cumberland at the Divisional Gala at

Widnes. While the number of children gaining County and R.L.S.S. Awards in swimming and life-saving remains high, the overall standard of competitive swimming reflects the paucity of swimming facilities in the County as a whole. The value of competition and good facilities as media for improving performance is shown in those schools which now take part in the activities arranged by the recently formed Cumberland Schools' Gymnastic Association. In addition to raising the general level of performance in those schools, the results of the inter-County matches reflect favourably upon the efforts of teachers and selected pupils to match evenly the talents of Cumberland boys against their neighbours in Durham and Yorkshire. The Cumberland Schools' Sailing Association, enjoying the use of the base at Scarness, has a nucleus of enthusiastic schools which have found greater opportunity of meeting the demand of this popular sport among young people with the addition of five G.P.14's to the original complement of cadets. The enlargement of the jetty and the groundwork done for the new slipway are welcome improvements to the facilities, while the planned changing accommodation will meet an urgent need at the base. Some schools have made use of the area to associate camping with sailing, an arrangement which is advantageous in training young people for outdoor pursuits.

Whilst there has again been an increase in inter-school athletics competitions, more tennis courts are now available and it is becoming possible in some schools to offer a choice of activity in the Summer term to senior girls.

Training courses for primary school teachers have been held at Thursby and Millom, while outdoor activity courses for teachers and leaders have covered ski-ing, rock-climbing (including snow and ice), Duke of Edinburgh Award, canoe handling, white water canoeing, sailing and fell walking.

Expansion in the secondary, youth and adult fields of physical recreation leading to a broader and richer social life is not possible unless the basic training at the primary stage is fully effective. Continuous effort throughout the year can only be obtained if good indoor facilities are provided. Only then can a firm foundation of creative movement, informal

exploratory work and basic skill be laid. It is, therefore, pleasing to record that indoor facilities have been provided at Allhallows, St. Patrick's R.C. School, Maryport, Orgill Infants', Flimby, Kirkbampton, Skirwith, Stainton, Hensingham Infants' and Calthwaite. As the number of primary schools with good indoor facilities increases so will the secondary schools receive children ready to move immediately into the varied and concentrated programme of skill or movement training essential if a richer and fuller life is to be enjoyed in post-school years.

APPENDIX ' A '

MEDICAL INSPECTION AND TREATMENT

Part 1—Medical Inspection of Pupils attending Maintained Primary and Secondary Schools (including Nursery and Special Schools)

Table A—Periodic Medical Inspections

Age Groups inspected (By year of Birth) (1)	No. of Pupils who have received a full medical examination (2)	PHYSICAL CONDITION OF PUPILS INSPECTED			Pupils found to require treatment (excluding dental diseases and infestation with vermin)		Total individual pupils (8)
		PHYSICAL CONDITION OF PUPILS	Unsatisfactory No. (4)	No. of Pupils found not to warrant a medical examination. (5)	For defective vision (excluding squint) (6)	For any other condition recorded at Part II (7)	
		Satisfactory No. (3)					
1960 and later	42	42	—	—	3	4	7
1959	1774	1772	2	—	61	129	184
1958	2145	2138	7	—	68	151	214
1957	210	207	3	—	13	23	35
1956	551	551	—	671	32	31	63
1955	37	37	—	—	1	1	2
1954	1905	1903	2	—	68	143	209
1953	128	128	—	—	7	12	17
1952	507	507	—	524	31	18	49
1951	34	34	—	—	2	5	5
1950	3187	3187	—	—	140	193	326
1949 and earlier	250	248	2	—	8	17	25
TOTAL	10770	10754	16	1195	434	727	1136

Col. (3) total as percentage of Col. (2) total = 99.85%.
Col. (4) total as percentage of Col. (2) total = 0.15%.

Table B—Other Inspections

Number of Special Inspections	...	1,643
Number of Re-inspections	... ..	7,290
		<hr/>
Total	...	8,933
		<hr/>

Table C—Infestation with Vermin

(a) Total number of individual examinations of pupils in schools by school nurses or other authorised persons	... ..	117,583
(b) Total number of individual pupils found to be infested	... ..	1,204
(c) Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	... ..	19
(d) Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	... ..	—

Table D—Screening Tests of Vision and Hearing

1. (a)	Is the vision of entrants tested? ...	...	Yes.
(b)	If so, how soon after entry is this done? ...	...	Within 12 months.
2.	If the vision of entrants is not tested, at what age is the first vision test carried out? ...	...	—
3.	How frequently is vision testing repeated throughout a child's school life? ...	...	On entry, and at ages 8, 10 and 14.
4. (a)	Is colour vision testing undertaken? ...	...	Yes, when choice of occupation or career indicates testing advisable.
(b)	If so, at what age? ...	...	14 (school leaver group).
(c)	Are both boys and girls tested? ...	...	Yes.
5.	By whom is vision and colour testing carried out? ...	...	School medical officers and school nurses.
6. (a)	Is audiometric testing of entrants carried out? ...	...	Yes.
(b)	If so, how soon after entry is this done? ...	...	Within 12 months.
7.	If the hearing of entrants is not tested, at what age is the first audiometric test carried out? ...	...	—
8.	By whom is audiometric testing carried out? ...	...	County Audiometricians.

Part II—Defects found by Periodic and Special Medical Inspections during the year

Defect Code No.	Defect or Disease			PERIODIC INSPECTIONS								Special Inspection	
				Entrants		Leavers		Others		Total			
				(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)
(1)	(2)			(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
4	Skin	...	...	17	122	30	88	23	108	70	318	50	20
5	Eyes—a. Vision	...	...	126	459	140	574	175	722	441	1755	57	253
	b. Squint	...	...	11	42	1	23	6	35	18	100	5	11
	c. Other	...	...	7	20	7	20	5	22	19	62	5	8
6	Ears—a. Hearing	...	...	38	208	18	63	46	176	102	447	27	48
	b. Otitis Med	...	...	6	81	5	19	4	45	15	145	—	—
	c. Other	...	...	1	25	5	7	9	20	15	52	2	—
7	Nose and Throat	...	...	37	495	12	133	28	294	77	922	15	42
8	Speech	...	...	24	89	6	12	19	64	49	165	10	9
9	Lymphatic Glands...	...	...	5	100	—	9	2	24	7	133	—	6
10	Heart	...	...	7	86	3	83	5	106	15	275	—	4
11	Lungs	...	...	9	203	4	79	7	142	20	424	2	15
12	Developmental—	...	...	...	...	...	...	...	...	...	...	...	...
	a. Hernia	...	...	4	20	—	1	2	14	6	35	1	—
	b. Other	...	...	11	46	4	35	5	124	20	205	—	6
13	Orthopaedic—	...	...	...	...	...	...	...	...	...	...	...	...
	a. Posture	...	...	2	4	8	15	6	22	16	41	—	—
	b. Feet	...	...	33	110	64	71	47	117	144	298	10	1
	c. Other	...	...	19	123	30	75	29	122	78	320	9	19
14	Nervous System—	...	...	...	...	...	...	...	...	...	...	...	...
	a. Epilepsy	...	...	—	7	—	9	—	16	—	32	—	—
	b. Other	...	...	—	9	—	13	3	9	3	31	1	1
15	Psychological—	...	...	...	...	...	...	...	...	...	...	...	...
	a. Development	...	...	4	26	1	32	10	66	15	124	4	25
	b. Stability	...	...	3	82	—	21	11	74	14	177	3	16
16	Abdomen	...	...	6	45	1	35	7	48	14	128	5	5
17	Other	...	...	4	85	3	75	4	99	11	259	7	20

**Part III—Treatment of Pupils attending maintained Primary
and Secondary Schools (including Nursery and
Special Schools)**

Table A—Eye Diseases, Defective Vision and Squint

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	7
Errors of refraction (including squint)...	2,925
	<hr/>
Total	2,932
	<hr/>
Number of pupils for whom spectacles were prescribed	1,385

Table B—Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been dealt with
Received operative treatment—	
(a) for diseases of the ear	5
(b) for adenoids and chronic ton- sillitis	70
(c) for other nose and throat con- ditions	3
Received other forms of treatment ...	40
	<hr/>
Total	118
	<hr/>

**Total number of pupils in schools who
are known to have been provided
with hearing aids—**

(a) in 1964	18
(b) in previous years	81

Table C—Orthopaedic and Postural Defects

		Number of cases known to have been treated
(a) Pupils treated at clinics or out- patients departments ...	...	1,275
(b) Pupils treated at school for postural defects ...	...	—
Total ...	...	<hr/>1,275 <hr/>

Table D—Diseases of the Skin

(excluding uncleanliness, for which see Table C of Part I)

		Number of cases known to have been treated
Ringworm—(a) Scalp ...	...	1
(b) Body ...	...	—
Scabies ...	...	1
Impetigo ...	...	5
Other skin diseases ...	...	137
Total ...	...	<hr/>144 <hr/>

Table E—Child Guidance Treatment

	Number of cases known to have been treated
Pupils treated at Child Guidance clinics	506

Table F—Speech Therapy

	Number of cases known to have been treated
Pupils treated by speech therapists ...	545

Table G—Other Treatment Given

	Number of cases known to have been dealt with
(a) Pupils with minor ailments ...	109
(b) Pupils who received convalescent treatment under School Health Service arrangements ...	118
(c) Pupils who received B.C.G. vaccination ...	3,965
(d) Other than (a), (b) and (c) above	—
Total (a)—(d) ...	4,192

**Part IV—Dental Inspection and Treatment carried out by
the Authority**

(a) Dental and Orthodontic work:

(1) Number of pupils inspected by the
Authority's Dental Officers:—

(i) At Periodic Inspections 26,815

(ii) As Specials ... 228

Total 27,043

(2) Number found to require treatment 15,230

(3) Number offered treatment... 12,651

(4) Number actually treated ... 12,010

(b) Dental Work (other than orthodontics):

(1) Number of attendances made by
pupils for treatment, excluding
those recorded at (c) 1 below ... 25,185

(2) Half days devoted to:

(i) Periodic (School) In-
spections ... 253

(ii) Treatment ... 3,075

Total 3,328

(3) Fillings:			
(i)	Permanent Teeth	... 15,384	
(ii)	Temporary Teeth	... 1,544	
		<hr/>	Total 16,928
(4) Number of Teeth filled:			
(i)	Permanent Teeth	... 13,817	
(ii)	Temporary Teeth	... 1,507	
		<hr/>	Total 15,324
(5) Extractions:			
(i)	Permanent Teeth	... 4,955	
(ii)	Temporary Teeth	... 9,836	
		<hr/>	Total 14,791
(6) (i) Number of general anaesthetics given for extractions ...			3,321
(ii) Number of half days devoted to the administration of general anaesthetics by:			
(a)	Dentists	... 264	
(b)	Medical Practitioners	16	
		<hr/>	Total 280
(7) Number of pupils supplied with artificial teeth ...			364
(8) Other operations:			
(i)	Crowns	... 20	
(ii)	Inlays	... 28	
(iii)	Other Treatment...	6,655	
		<hr/>	Total 6,703
(c) Orthodontics:			
(1)	Number of attendances made by pupils for orthodontic treatment...		1,140
(2)	Half days devoted to orthodontic treatment ...		92

(3)	Cases commenced during the year	223
(4)	Cases brought forward from the previous year 	224
(5)	Cases completed during the year...	59
(6)	Cases discontinued during the year	21
(7)	Number of pupils treated by means of appliances 	156
(8)	Number of removable appliances fitted 	167
(9)	Number of fixed appliances fitted...	10
(10)	Cases referred to and treated by Hospital Orthodontists 	248

APPENDIX B

Handicapped Pupils requiring Education at Special Schools approved under Section 9(5) of the Education Act, 1944, or Boarding in Boarding Homes.

During the calendar year ended 31st December, 1964	(1) Blind (2) Partially sighted		(3) Deaf (4) Partial hearing		(5) Physically (6) Handicapped (6) Delicate		(7) Maladjusted (8) E.S.N.		(9) Epileptic (10) Speech Defects		(11) Total Cols. (1)-(10)	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	
A. How many handicapped pupils were newly assessed as needing special educational treatment at special schools or in boarding homes?	—	—	4	—	2	—	1	31	1	—	—	39
B. (i) of the children included at A, how many were newly placed in special schools (other than hospital special schools) or boarding homes?	—	—	2	—	1	—	—	7	1	—	—	11
(ii) of the children assessed prior to 1st January, 1964, how many were newly placed in special schools (other than hospital special schools) or boarding homes?	1	2	1	—	—	—	—	18	—	—	—	22
Total B(i) and B(ii)	1	2	3	—	1	—	—	25	1	—	—	33

On 28th January, 1965, how many handicapped pupils from the Authority's area:—

[illegible]

During the calendar year ended
31st December, 1964

During the calendar year ended 31st December, 1964											
	(1) Blind (2) Partially sighted	(3) Deaf (4) Partial hearing	(5) Physically Handicapped (6) Delicate	(7) Maladjusted (8) E.S.N.	(9) Epileptic (10) Speech Defects	Total Cols. (1)-(10)					
(2) non-maintained special schools as—	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
(a) day pupils	—	—	—	—	—	—	—	—	—	—	—
(b) boarding pupils	7	3	13	7	6	1	—	—	3	—	40
(ii) were on the registers of inde- pendent schools under arrange- ments made by the Authority	—	—	—	—	4	—	—	1	—	—	5
Total D(i) and D(ii)	7	4	13	7	11	1	—	85	3	—	131
(iii) were boarded in homes and not already included under (i) and (ii) above	—	—	—	—	—	—	—	—	—	—	—
Total [D(i), (ii) and (iii)]...	7	4	13	7	11	1	—	85	3	—	131
E. On or about 23rd January, 1965, how many handicapped pupils (irrespective of the areas to which they belong) were being educated under arrangements made by the Authority in accordance with Sec- tion 56 of the Education Act, 1944											
(i) in hospitals	—	—	—	—	12	—	—	—	—	—	12
(ii) in other groups (e.g., units for spastics, convalescent homes)	—	—	—	—	—	—	—	—	—	—	—
(iii) at home	1	—	—	—	6	—	1	—	—	—	8

APPENDIX C

SCHOOL HEALTH SERVICE CLINICS AS AT 31.12.64

(Actual school clinic work as distinct from special clinics is being carried out either in conjunction with child welfare clinic sessions or as specially required).

ALSTON:

Dental—2nd and 4th Tuesday—all day.

ASPATRIA:

Dental—2nd and 4th Friday—all day.

Orthopaedic Aftercare—2nd Friday p.m., 4th Friday a.m.

Speech Therapy—Alternate Tuesday a.m.

BRAMPTON:

Dental—Each Tuesday and Wednesday—all day.

Orthopaedic Aftercare—1st Tuesday a.m.

CARLISLE:

Dental—Each Monday and Friday—all day.

At Eden School each Thursday—all day.

At Caldew School—1st, 3rd and 5th Friday—all day.

Eye Specialist—Each Monday and Thursday a.m.

Orthoptic—Each Monday—all day; Friday p.m.

E.N.T. Specialist—Monday p.m. as required.

Child Guidance—Each Thursday p.m.

Speech Therapy—Each Tuesday and Thursday a.m.; each Friday p.m.

Orthopaedic Aftercare—Each Tuesday p.m.

Orthopaedic Surgeon—1st Monday every odd month p.m.; 1st Monday every fourth month a.m. and occasionally as required.

CLEATOR MOOR:

Dental—Each Tuesday—all day.

Orthopaedic Aftercare—1st and 3rd Tuesday p.m.

COCKERMOUTH:

Dental—Each Monday, Tuesday, Wednesday and Friday—all day.

Orthopaedic Aftercare—1st and 3rd Wednesday—all day.

Speech Therapy—Each Thursday—all day.

EGREMONT:

Dental—Each Monday—all day.

Orthopaedic Aftercare—1st and 3rd Tuesday a.m.

KESWICK:

Dental—Each Thursday—all day.

Speech Therapy—Each Friday a.m.

Orthopaedic Aftercare—3rd Monday—all day.

LONGTOWN:

Dental—Each Monday—all day.

MARYPORT:

Dental—Each Monday and Thursday—all day.

Speech Therapy—Alternate Wednesday—all day.

Orthopaedic Aftercare—2nd and 4th Tuesday—all day.

Child Guidance—Each Monday p.m.

MILLOM:

Dental—Each Monday, Tuesday, Wednesday and Friday
—all day.

Child Guidance—Thursday p.m. as required.

Orthopaedic Aftercare—3rd Monday a.m.

Eye Specialist—1st and 3rd Friday a.m.

PENRITH:

Dental—Each Tuesday, Wednesday, Thursday and
Friday—all day.

Speech Therapy—Tuesday a.m.; Wednesday—all day.

Orthopaedic Aftercare—2nd and 4th Wednesday—all day.

Orthopaedic Surgeon—1st Monday every fourth month
p.m.

SEASCALE:

Dental—Each Thursday—all day.

Orthopaedic Aftercare—3rd Monday p.m.

SALTERBECK:

Dental—Each Monday and Thursday—all day; each
Wednesday p.m.

SILLOTH:

Dental—1st, 2nd and 3rd Thursday—all day.

Orthopaedic Aftercare—3rd Friday p.m.

WHITEHAVEN (FLATT WALKS):

Dental—Each Monday, Wednesday, Thursday and Friday—all day.

Whitehaven Grammar School—Each Wednesday—all day.

School—Daily a.m. with medical officer attending each Wednesday morning.

E.N.T. Specialist—Tuesday a.m. as required.

Eye Specialist—Each Monday, Wednesday and Thursday a.m.

Speech Therapy—Alternate Tuesday p.m.; Wednesday and Thursday—all day.

Orthopaedic Aftercare—Each Thursday—all day.

Orthopaedic Surgeon—1st Friday every odd month a.m.;
2nd Friday every even month a.m. and occasionally as required.

Child Guidance—Each Wednesday p.m. Each Friday a.m.

WHITEHAVEN (MIREHOUSE):

Dental—Thursday—all day.

WIGTON:

Dental—Each Tuesday and Wednesday—all day.

Speech Therapy—Alternate Thursday—all day.

Orthopaedic Aftercare—3rd Friday a.m.

WORKINGTON (STONELEIGH):

Dental—Each Tuesday and Friday—all day; Each Wednesday p.m.

WORKINGTON (PARK LANE):

Dental—Daily—all day.

School—Each Tuesday a.m.

Speech Therapy—Each Monday—all day; alternate Tuesdays a.m.

Orthopaedic Aftercare—Each Friday p.m. and 2nd and 4th Friday a.m.

Orthopaedic Surgeon—1st Friday every even month a.m.;
2nd Friday every odd month a.m. and occasionally as required.

Child Guidance—Each Wednesday a.m.

APPENDIX D.

CONFIDENTIAL

H.S.54

(amended Jan., 1964)

CUMBERLAND COUNTY COUNCIL SCHOOL HEALTH SERVICE

To ALL Parents:—

Please fill in this form and send it back to school in the envelope. There is no need to give information you have given before. Please see also that the NAME, ADDRESS and DATE OF BIRTH are filled in correctly.

Dear Sir or Madam,

Name of Child..... Date of Birth.....

Address Day.....Month.....Year.....

.....

1. Your child may be selected for medical examination shortly. If so you will be asked to come to see the School Doctor at the time.
2. Your child is due for medical examination at
on..... at..... a.m./p.m.
and the School Doctor would like to see you then if possible.

Yours faithfully,

JOHN LEIPER,

Principal School Medical Officer.

Infectious Illnesses. [Please tick which your child has had and say how old (s)he was].

Age

Vaccinations and Immunisations.
[Please tick which (s)he has had.]

District where done Age

Whooping Cough

For Smallpox

Measles

„ Diphtheria

Scarlet Fever

„ Whooping Cough

Mumps

„ Tetanus

Chicken Pox

„ Tuberculosis
(B.C.G.)

German Measles

„ Poliomyelitis

NOTE.—“Triple” includes protection against Diphtheria, Whooping Cough and Tetanus. One injection against Tetanus after an injury does not count.

[P.T.O.]

OTHER ILLNESSES, OPERATIONS OR ACCIDENTS. Please say how old (s)he was and if (s)he was in hospital, or off school, for a long time

.....

.....

.....

.....

.....

.....

If (s)he has, or has had in the past year, any of these, please mark them with a tick:—

Deafness	Nervousness
Poor eyesight	Asthma, bronchitis or chronic cough
Headaches	Rheumatism or joint pains
Tonsillitis	Weakness of hands, arms, legs or feet
Catarrh	Fits or fainting attacks
Earache	Bed-wetting
Discharge from the ear	Backwardness or difficult behaviour
Faulty speech	

Is your Doctor treating any of these now? Which.....

.....

.....

Please note here anything you wish specially to speak to the School Doctor about

Is there any family illness or condition which might also affect your child? (e.g., Squint, deafness, fits, asthma, stammering).....

.....

.....

Father's occupation

Mother's occupation

PLEASE GIVE THE NAME OF YOUR FAMILY DOCTOR.....

Signed..... Date.....

